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BRIEFING BOOK

MEDICAL MALPRACTICE: BY THE NUMBERS

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PART 1: MEDICAL MALPRACTICE LITIGATION

❖ EXPERTS AGREE THAT WHEN CASES ARE FILED, THEY ARE NOT “FRIVOLOUS”; FEW INJURED PATIENTS FILE CLAIMS OR LAWSUITS.

“2017 Civil Caseloads – Trial Courts: 2017 Statewide Medical Malpractice Caseloads and Rates,” National Center for State Courts, 2018.

According to averages calculated from the most recent data released by the National Center for State Courts (2017):

- Medical malpractice cases represented only 0.14 percent of state *civil* caseloads in 2017.¹ This rate is consistent with NCSC data from the previous five years.²
- Medical malpractice cases represented only 3.9 percent of state *tort* caseloads in 2017.³ This rate is consistent with NCSC data from the previous five years.⁴

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2018.

- “[M]edical liability insurers have always known that most patients who bring medical malpractice claims have suffered significant injuries, and that many of those claims meet the legal standard for tort liability. They have also known that many of those injuries are preventable and, thus, that hospitals and other places where patients receive care still have room for improvement.”⁵
- “[P]atients must sue to obtain recoveries and, to sue successfully, they must hire attorneys. Because malpractice cases are expensive to prepare and are defended zealously by insurers, plaintiffs’ attorneys choose cases with care.”⁶

“Composition of Tort Caseloads in 20 States, 2016,” National Center for State Courts, 2018.

According to averages calculated from the most recent data released by the National Center for State Courts (2016), medical malpractice cases represent only 4 percent of state *tort* caseloads.⁷ This rate is consistent with NCSC data from the previous four years.⁸

“2016 Civil Caseloads – Trial Courts: 2016 Statewide Medical Malpractice Caseloads and Rates,” National Center for State Courts, 2017.

According to averages calculated from the most recent data released by the National Center for State Courts (2016), medical malpractice cases represent only 0.17 percent of state *civil* caseloads.⁹ This rate is consistent with NCSC data from the previous four years.¹⁰

“Medical Harm: Patient Perceptions and Follow-up Actions,” Johns Hopkins University School of Medicine Professor of Surgery Marty Makary, M.D., M.P.H., et al., 2014.

Researchers found that a lawsuit was filed on behalf of the patient in 19.9 percent of harms. In other words, “approximately 1 in 5 patient harms resulted in a lawsuit.” As the authors explained, “This is similar to the Harvard Medical Practice Study, which reported an estimated ratio of adverse event to malpractice claim of 7.6:1. Other studies have estimated that as few as 2% to 3% of patients pursue litigation. These findings all suggest that the vast majority of patient harms never result in a lawsuit.”¹¹

“Measuring Diagnostic Errors in Primary Care,” Johns Hopkins University School of Medicine Associate Professor of Surgery Martin Makary, M.D., M.P.H. and Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, M.D., Ph.D., 2013.

“Only about 1% of adverse events due to medical negligence result in a claim.”¹²

***Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick*, Public Citizen, 2014.**

Public Citizen’s most recent analysis of National Practitioner Data Bank (NPDB) data found that there were 3,046 medical malpractice payments for deaths due to negligence in 2013.¹³ This means that even if one uses the low end of the IOM estimate – 44,000 deaths per year – about 14 times as many people were likely killed in hospitals in 2013 because of avoidable errors as the number of malpractice payments to survivors.¹⁴ Using a 2009 Hearst Newspapers estimate (*i.e.*, 200,000 deaths from medical mistakes per year), just one in 65 deaths was compensated.¹⁵ In other words, between 93 and 98 percent of deaths from medical negligence did not result in any liability payment.

Darshak Sanghavi, M.D., Chief of Pediatric Cardiology at the University of Massachusetts Medical School, 2013.

“Contrary to many doctors’ beliefs, there is no epidemic of frivolous lawsuits” and “when doctors make an actual mistake, the system is slightly biased in their favor.”¹⁶

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

Experts say that those who try to argue that the system is flooded with frivolous lawsuits deceptively interchange the terms “claims” and “lawsuits” to try to make their case. In other words, “[M]isleading impressions about the medical malpractice system, such as the AMA’s statement that ‘75 percent of medical liability claims are closed without a payment to the plaintiff’ (AMA 2006) depend wholly on failing to distinguish between weak cases, which tend not receive payment, and strong cases, which every study shows to receive payment at a higher rate than that suggested by the AMA. Distinguishing between the two groups of studies is important because a claim presented to an insurer is not the same as a lawsuit. And claims against multiple defendants may lead to recovery from only one, leaving three claims without a payment but an incident with evidence of negligence.”¹⁷

Victor Schwartz, General Counsel, American Tort Reform Association, 2011.

“It is ‘rare or unusual’ for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring.”¹⁸

“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” Harvard School of Public Health, 2006.

- “[P]ortraits of a malpractice system that is stricken with frivolous litigation are overblown.”¹⁹
- Lead author, David Studdert, Associate Professor of Law and Public Health at HSPH, said, “Some critics have suggested that the malpractice system is inundated with groundless lawsuits, and that whether a plaintiff recovers money is like a random ‘lottery,’ virtually unrelated to whether the claim has merit. These findings cast doubt on that view by showing that most malpractice claims involve medical error and serious injury, and that claims with merit are far more likely to be paid than claims without merit.”²⁰ The authors found:²¹
 - Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.
 - “The profile of non-error claims we observed does not square with the notion of opportunistic trial lawyers pursuing questionable lawsuits in circumstances in which their chances of winning are reasonable and prospective returns in the event of a win are high. Rather, our findings underscore how difficult it may be for plaintiffs and their attorneys to discern what has happened before the initiation of a claim and the acquisition of knowledge that comes from the investigations, consultation with experts, and sharing of information that litigation triggers.”

- “Previous research has established that the great majority of patients who sustain a medical injury as a result of negligence do not sue. ... [F]ailure to pay claims involving error adds to a larger phenomenon of underpayment generated by the vast number of negligent injuries that never surface as claims.”

❖ THE NUMBER (“FREQUENCY”) AND SIZE (“SEVERITY”) OF MEDICAL MALPRACTICE CLAIMS, LAWSUITS AND PAYOUTS, ARE LOW.

Medical Malpractice in America: A 10-Year Assessment With Insights, CRICO Strategies, 2019.

- “Overall MPL case frequency dropped 27% from 2007-2016, with an especially compelling trend for obstetricians-gynecologists.”
- “Fewer cases are being asserted relative to the physician population. The 2016 rate, 3.7 cases per 100 physicians, reflects a steady downward trend.”
- “For ob/gyns (whose rate is historically higher than the average for all MDs), the risk of having an MPL case filed against them dropped 44% from 2007–2016.”
- On average, from 2007-2016, 70 percent of cases closed without payment.
- “MPL indemnity payment trends for the 10-year study period were not dramatic. The median payment increased in line with inflation (from \$110K in 2007, to \$120K in 2016). The average payment, even though distorted by a few atypical payouts, grew on average 3% annually (from \$298K to \$360K). While that outpaced the consumer price index, it fell below medical inflation, a fair proxy for medical expenses which, along with policy limits, heavily influence payments.”
- “Certainly, extraordinary jury awards draw media attention, pique the interest of reinsurers, and can skew the focus of patient safety improvements, but they remain rare. Per 1,000 cases closed, only one or two cases closed with more than \$5 million indemnity. Outlier payments (those exceeding \$11M) had a minimal impact on overall indemnity trends.”²²

“State of the Medical Professional Malpractice Liability Insurance Market,” A.M. Best Webinar, 2019.

“Severity (size of claims) always increases due to medical inflation. However, if severity is rising, look to changes in health care. With the growing migration of doctors into hospital systems, there inevitably will be one larger combined payout instead of fewer smaller payouts split between doctors and hospitals. However, that does not lead to an impact in insurers’ overall costs.”

Study of Malpractice Claims Involving Children, The Doctors Company, 2019.

The med mal insurer examined over 1,200 pediatric patient claims filed against doctors that closed from 2008-2017 and found that only 37 percent resulted in payment.²³

“Annual Rate Survey Issue,” Medical Liability Monitor, 2018.

“[C]laim frequency remains lower, generally stable and fewer claims make it to trial.”²⁴

“Annual Rate Survey Issue,” Medical Liability Monitor, 2017.

- “[C]laim frequency remains relatively flat and near historic lows across the MPL [medical professional liability] industry....”²⁵
- “A number of carriers and large hospital systems report continuing stable, and in some jurisdictions even lower, claim frequency in recent years. This view is echoed by the survey participants – with almost 80 percent of respondents noting that frequency has been flat during the last two years....”²⁶

“HealthTrek: Medical malpractice claim trends in 2017,” Willis Towers Watson, June 15, 2017.

- “In 2017, the national environment for [health care professional liability] continues to be mostly favorable for many reasons. The most notable one is continued low claim frequency.”²⁷
- “The favorable national medical malpractice environment continued to inure to the benefit of physicians in all but a handful of states. Claim frequency overall and for physicians remains at a historic low and shows no sign of a turn for the worse.”²⁸

Medical Professional Liability Sector: Solid Results Despite Growing Headwinds and Deteriorating Profitability, A.M. Best, 2017.

- “[C]laims frequency remains quite low while severity has increased modestly.”²⁹
- Insurance companies admit that to the extent there is a modest severity increase, it is related to “inflation of defense costs” – in other words, inflation connected to what they pay their own people to fight claims, and not “indemnity severity,” *i.e.*, settlements or verdicts.³⁰

“Rates and Characteristics of Paid Malpractice Claims Among US Physicians by Specialty, 1992-2014,” Brigham and Women’s Hospital Hospitalist Adam C. Schaffer, M.D. et al., 2017.

An analysis of all paid malpractice claims from the National Practitioner Data Bank from 1992-1996 to 2009-2014 revealed the following:³¹

- The overall rate of claims paid on behalf of physicians dropped by 55.7 percent.
- Only 7.6 percent of paid claims exceeded \$1 million.
- 32.1 percent of paid claims involved a patient death.
- Error in diagnosis was the most common type of allegation, present in 31.8 percent of paid claims, followed by surgical errors (26.9 percent) and errors related to medication or treatment (24.5 percent).

Stable Losses/Unstable Rates 2016, Americans for Insurance Reform, 2016.

- When adjusted for medical care inflation, claims per physician are currently at their lowest level in four decades.³²
- When adjusted by urban consumers CPI index (a more conservative inflationary adjustment), claims are at their lowest since 1982.³³
- Total medical malpractice payouts have never spiked and have generally tracked the rate of inflation.³⁴

“Leading Republicans See A Costly Malpractice Crisis – Experts Don’t,” *Kaiser Health News*, December 30, 2016.

According to the Doctors Company, one of the nation’s largest malpractice insurers, “the rate of claims has dropped by half since 2003.”³⁵

“State of the Medical Professional Malpractice Liability Insurance Market,” A.M. Best Webinar, 2016.

Richard Anderson, CEO, The Doctors Company: “The frequency of claims is flat and in fact, is at its lowest level in our history. This is the new normal. What’s surprising is that by 2016, we would have predicted an uptick in claims due to changes in the Affordable Care Act. But we are not seeing it. There has been no increase in claims and no novel claims. As to severity of claims, it is the same thing. Severity never falls. It always increases. But we see a more moderate increase than a decade ago. Only about 4 percent a year.”

2013 Hospital and Physician Professional Liability Benchmark Analysis, AON Risk Solutions and American Society for Healthcare Risk Management, 2013.

- “The cost of medical malpractice [claims] is growing at the slowest rate in the fourteen year history of the Aon/ASHRM Hospital and Physician Professional Liability Benchmark report.”³⁶
- “‘We project zero growth in the number of malpractice claims,’ said Erik Johnson, health care practice leader for Aon’s Actuarial and Analytics Practice and author of the analysis. ‘Health care professional liability claims are subject to a complicated set of geographic, societal, and technological influences. These forces are largely in-check, resulting in a low inflationary environment for medical malpractice.’”³⁷

“The Receding Tide of Medical Malpractice Litigation Part 1: National Trends,” University of Illinois Professor of Law and Medicine David A. Hyman et al., 2013.

Hyman and colleagues Bernard S. Black and Myungho Paik, both from Northwestern University, found:³⁸

- “[A]ll states have experienced large drops in paid claims per physician and payout per physician....[T]he per-physician rate of paid med mal claims has been dropping for 20 years and in 2012 is less than half the 1992 level.”
- “We find large drops in paid claim rates per active physician nationally and in no-cap states. ... From 1992-2012, paid claims per physician dropped by 57% nationally, including 51% in the 20 no-cap states, 57% in the 19 old-cap states, and 64% in the 12 new-cap states.”
- “This trend applies to med mal suits generally, not just to paid claims and not just to claims against physicians. We find similar trends for med mal lawsuits in the 18 states where we have data on lawsuits.”
- “Some of the decline in paid claims reflects a large drop (72%) in the number of small paid claims (payout < \$50k). These small claims are being squeezed out of the tort system, presumably because the expected recovery does not justify the cost of bringing them. But, we also find a sustained drop in “large” paid claims (> \$50k) beginning no later than 2001. These claims account for 98% of payout dollars. Over 1992-2012, large paid claims dropped nationally by 49%, including 40% in no-cap states, 49% in old-cap states, and 60% in new-cap states.”
- “Payouts per physician have been dropping since 2003, and by 2012 were 48% below their 1992 level.”
- “Between 1992 and 2001, payout per physician rose somewhat from \$7,500 to \$8,200. Since then, it has plummeted to \$3,850 in 2012.”

❖ A SMALL NUMBER OF DOCTORS ARE RESPONSIBLE FOR MOST MALPRACTICE PAYOUTS; INCOMPETENT PHYSICIANS ARE RARELY HELD ACCOUNTABLE BY STATE MEDICAL BOARDS OR THE FEDERAL GOVERNMENT.

“Changes in Practice among Physicians with Malpractice Claims,” Stanford University Professor of Medicine and Law David M. Studdert, LL.B., Sc.D., M.P.H., et al., 2019.

Researchers examined Medicare and NPDB data on paid claims against 480,894 doctors from 2003-2015 and found the following:³⁹

- Roughly 2 percent of physicians accounted for almost 40 percent of all paid medical malpractice claims.
- “[M]ore than 90 percent of doctors who had at least five claims were still in practice.”
- The “overwhelming majority of doctors who had five or more paid claims...moved to solo practice and small groups more often, where there’s even less oversight, so those problematic doctors may produce even worse outcomes. ...This makes sense, in some ways. Doctors with many claims may find it harder to find employment in large groups or in big clinics. Anyone can, however, set up his or her own practice. The general public is much less likely than a potential employer to seek out information about prior lawsuits.”
- ““There is an emerging awareness that a small group of ‘frequent flyers’ accounts for an impressively large share of all malpractice lawsuits,”” said the study’s lead author.⁴⁰

“Info on doctors is hard to find,” Investigative Post, April 11, 2019.

- “In 2017, almost 1,400 doctors, across [New York State], were on probation. There were more than 75,000 doctors licensed in New York, as of January 2019. Being put on probation is a less serious disciplinary action than a license revocation, or suspension, but more serious than a fine or reprimand.”
- “The onus is on patients to find this kind of information – rather than on hospitals or doctors to proactively disclose it. If a doctor is on probation, for instance, there’s no legal requirement that they tell patients. New York isn’t unusual in this regard.”⁴¹

“Hundreds of Florida doctors with multiple malpractice payouts still seeing patients,” *ABC Action News*, May 20, 2019.

- “Hundreds of Florida doctors have paid out multiple malpractice claims – putting patients at risk 15 years after voters passed a law that was supposed to take away their licenses.”
- “The I-Team found at least 120 Florida doctors who racked up three or more malpractice claims over the past decade and state records show only two doctors have had their licenses revoked under the three strikes rule.”
- One doctor “paid out 16 malpractice claims since 2000 – including six cases involving patient deaths. State records show his insurance paid out a total of \$2.6 million in those cases.”⁴²

“Doctors who surrender a medical license in one state can practice in another – and you might never know,” *Milwaukee Journal Sentinel/USA TODAY*, November 30, 2018.

- “More than 250 doctors who surrendered a medical license were able to practice in another state, an investigation by the Milwaukee Journal Sentinel, USA Today and MedPage Today found.”⁴³
- “In a third of the 250 cases, doctors who surrendered their licenses were able to practice elsewhere without any limitations or public disclosure, simply by changing their addresses. In the other cases, they faced disciplinary action that patients might not be able to find out about.”
- “States can take action against doctors based on license surrenders in other places. But, as with other matters in the broken world of doctor discipline, such a step is spotty. Some states don’t even search a national database of troubled physicians. What’s more, voluntary license surrenders can mean the public gets no access to information about what happened, putting future patients at risk.”

“Georgia dental board inaction could leave patients at risk,” *Atlanta Journal-Constitution*, September 20, 2018.

“[P]ublic records show that some dentists have been allowed to practice even after repeated complaints about the quality of care. Other potentially dangerous dentists also have been allowed to stay in practice. In one case, over the past 15 years, the board has provided at least half a dozen chances to a drug-addicted dentist.”⁴⁴

“State Boards Turn Blind Eye to FDA-Sanctioned Docs,” *MedPage Today/Milwaukee Journal Sentinel/USA TODAY*, August 16, 2018.

- Only one of “73 doctors around the country with active medical licenses who got FDA warning letters over a 5-year period alleging serious problems” was disciplined by his state medical board. Such letters are “sent after FDA officials conduct inspections at offices, clinics, and medical facilities to determine if federal rules designed to protect patients are being violated.”⁴⁵
- “In all, 28 states have doctors who have been warned yet have been allowed to practice unfettered.”
- “State boards took no action on a wide range of problems: Fertility clinics that didn’t test donors of eggs and sperm for communicable diseases; researchers who didn’t follow rules designed to protect patients who volunteer for trials of drugs and devices; and doctors...who pushed dubious treatments and supplements to unwitting customers.”

“More than 200 doctors stay on Medicare rolls despite disciplinary actions,” *MedPage Today/Milwaukee Journal Sentinel*, May 18, 2018.

“Doctors who land in hot water with state regulators have a helping hand when it comes to keeping their practices running: The federal government. At least 216 doctors remained on Medicare rolls in 2015 despite surrendering a license, having one revoked, or being excluded from state-paid health care rolls in the previous five years, a Milwaukee Journal Sentinel/MedPage Today investigation found. In all, these doctors were paid \$25.8 million by taxpayers in 2015 alone.”⁴⁶

“From hope to medical nightmare,” *Milwaukee Journal Sentinel/MedPage Today*, March 28, 2018.

“Preying on desperate patients’ hope, doctors sell controversial MS treatment without consequence. Some require patients to pay as much as \$10,000 up front for a procedure they say treats a chronic condition linked to multiple sclerosis. But the FDA has warned the procedure doesn’t work and is not safe.... Yet, despite the repeated federal government warnings to stop what they’re doing, we found at least 30 doctors continuing to sell the unproven MS treatment in many states – without discipline – even as patients remain in the dark.

“One reason: A lack of communication between the FDA, which oversees medical research, and state medical boards, which regulate the practice of medicine. One California doctor acknowledges doing the procedure 2,000 times and has been the subject of three FDA warning letters alleging violations of federal regulations designed to keep patients safe. But none of the three states where he’s licensed to practice medicine took any public action against his license until after USA Today reported his story.”⁴⁷

“NPDB Records Often Ignored in Docs’ Licensing,” *MedPage Today/Milwaukee Journal Sentinel*, March 7, 2018.

- “The National Practitioner Data Bank – the government-sponsored repository for records of medical malpractice judgments and certain other adverse actions – has always been a boogeyman for physicians, a secretive list where you don’t want your name to appear. But at least one regulatory group isn’t paying that much attention to whether physicians are named in it or not.”⁴⁸
- “In 2017, 30 state medical boards in the U.S. backgrounded a physician using the database fewer than 100 times, according to numbers from the Health Resources and Service Administration. Thirteen boards didn’t even check it once. While there are other tools for boards to learn about troubles faced by the physicians they license, experts say the NPDB – despite its limitations – is a key part of any backgrounding process.”⁴⁹

“Prescription for Secrecy,” *MedPage Today/Milwaukee Journal Sentinel*, February 28, 2018.

- “Stories about individual doctors avoiding discipline in a second state have been reported before. An investigation by the *Milwaukee Journal Sentinel* and *MedPage Today* shows how widespread the problem is: At least 500 physicians who have been publicly disciplined, chastised or barred from practicing by one state medical board have been allowed to practice elsewhere with a clean license. And their patients are kept in the dark – even as more become victims – thanks to an antiquated system shrouded in secrecy.”⁵⁰
- “Among the more than 500 doctors identified by the *Journal Sentinel* and *MedPage Today*, the single biggest reason for board action was medical errors or oversights. One fifth of the cases were a result of putting patients in harm’s way. All have slipped through a system that makes it difficult for patients, employers and even regulators in other states to find out about their troubling pasts. The list represents a fraction of the nation’s roughly 200,000 physicians who hold licenses in more than one state, but likely far underestimates the scope of the problem.”⁵¹

“Targeting Bad Doctors: Lessons from Indiana, 1975-2015,” Georgetown University Law Professor David Hyman and University of Illinois Graduate Research Assistant Jing Liu, 2018.

After studying forty-one years of closed case data from Indiana that covered the disciplinary and med mal records of almost 30,000 physicians, researchers found the following:⁵²

- “[A] small number of physicians accounted for a heavily disproportionate share of med mal claims. Only 5% of physicians had five or more claims, but they accounted for 45% of all claims and 49% of paid claims.”

- “Even physicians with multiple paid claims are unlikely to be disciplined, and a large share of disciplined doctors had no med mal claims or had no paid claims. Indeed, fully 92% of repeat med mal defendants with 2 or more paid med mal claims were not sanctioned.”
- “Sanctions were not particularly severe, even for physicians who were tagged by both [the medical malpractice and state licensure/disciplinary] systems.”

“Dangerous Doctors: Malpractice lawsuits rarely lead to discipline,” *South Florida Sun Sentinel*, November 19, 2017; “Dangerous Doctors: Despite malpractice charges, Florida lets them keep treating patients,” *South Florida Sun Sentinel*, October 26, 2017.

- “The state Department of Health is required to review every malpractice lawsuit filed against Florida doctors to identify and punish problem doctors. Those reviews rarely lead to discipline, a *South Florida Sun Sentinel* investigation found. The department has reviewed nearly 24,000 resolved state and federal lawsuits against doctors over the past decade but has filed disciplinary charges just 128 times – about one-half of one percent of the cases, records show. While medical malpractice cases are often settled, even those that end in judgments against doctors go unpunished by Florida’s health regulators.”⁵³
- Florida regularly allows doctors to continue to see, treat, and operate on people for years after accusing them of endangering patients.

“Doctors on Probation Aren’t Required to Disclose Deadly Medical Mistakes to Patients,” *NBC Bay Area*, May 15, 2017.

- “More than 600 physicians and surgeons across [California] are currently on probation for a wide-range of violations including sexual assault, insurance fraud, and medical negligence that has resulted in the deaths of patients. Despite the severity of such violations, the Medical Board does not require doctors to notify their patients of their probation status.”⁵⁴
- “Each year, the board receives more than 8,000 complaints concerning physicians and surgeons, with only a few hundred of those complaints resulting in discipline. But even when investigators determine a doctor acted inappropriately, it takes an average of 909 days from when a complaint is submitted before a physician faces any kind of penalty. State regulations allow nearly all of those doctors to continue to see patients in the meantime.”⁵⁵

“The Detection, Analysis, and Significance of Physician Clustering in Medical Malpractice Lawsuit Payouts,” former U.S. Department of Health and Human Services Division of Practitioner Data Banks Associate Director for Research and Disputes Robert E. Oshel, Ph.D. and St. Mary’s Medical Center Neurosurgeon Philip Levitt, M.D., 2016.

- “Fewer than 2% of all physicians reporting to National Practitioner Data Bank (NPDB) over the past 25 years were responsible for half of all settlements, a total of more than \$41 billion....”⁵⁶
- “Physicians who were in the high dollar payout category and had one malpractice claim payout had a 74.5% chance of another payout, more than twice the rate for all physicians who had a single payout.... The likelihood that that physician would have additional payments increased as the number of previous payments increased. Total dollar payouts per physician better predicted future payouts than numbers of payouts.”⁵⁷
- “Because those physicians in the group responsible for 50% of the dollars paid were more likely to have higher payments and to be repeaters than the entire group for the most commonly occurring numbers of payments, it suggests that the best way to identify physicians requiring intervention involves examining the total malpractice dollars paid by physicians.”⁵⁸
- Though 1.8 percent of all physicians were responsible for half the malpractice payments from September 1, 1990 through June 30, 2015, “only a small percentage of those reporting to the data bank lost clinical privileges or were subject to action by licensing boards.”⁵⁹ More specifically, “12.6% had an adverse licensure action reported to the NPDB, and 6.3% had a clinical privileges action reported.”⁶⁰
- “The lack of effective action by licensing boards and peer reviewers is a source of distrust of the medical profession. Given the existence of an outlier group responsible for a high proportion of malpractice payments, whether measured by numbers of payments or total dollar amount of their payments, the rates of discipline among those groups beg the question of the efficacy of peer review at the state boards and hospitals.”⁶¹

“Prevalence and Characteristics of Physicians Prone to Malpractice Claims,” Stanford University Professor of Medicine and Law David M. Studdert, LL.B., Sc.D., M.P.H., et al., 2016.

According to the study, which reviewed National Practitioner Data Bank consisting of 67,000 paid claims against more than 54,000 physicians from 2005 through 2014:

- “Approximately 1% of all physicians accounted for 32% of paid claims.”⁶²
- “Neurosurgeons, orthopedic surgeons, general surgeons and obstetrician-gynecologists were among those who faced double the risk of future claims,

compared with internal medicine physicians, the study showed.”⁶³

- However, the risk of a future claim was due to a physician’s past claims history, not their specialty. “The most important predictor of a claim appeared to be a physician's past claims history. Compared with doctors with one previous paid claim, those with two paid claims had almost twice the risk of having another. Physicians with three paid claims had three times the risk. Those with six or more had more than 12 times the risk, the study found.”
- According to the study’s lead author, Stanford University Professor of Medicine and Law David Studdert, “The results suggest it may be possible to identify ‘claim-prone’ physicians and intervene before they encounter additional claims. I think a lot of liability insurers and health care organizations have not taken that analytical step to really understand who these folks are.”

“What You Don’t Know About Your Doctor Could Hurt You,” *Consumer Reports*, 2016.

- “A very small percentage of doctors have accounted for most of the country’s medical malpractice payouts over the last quarter century. That’s according to an analysis done for Consumer Reports of the National Practitioner Data Bank, a federal repository that has collected disciplinary actions and medical malpractice payouts since 1990.
- “[L]ess than 2 percent of the nation’s doctors have been responsible for half of the total payouts since the government began collecting malpractice information.”
- “Thousands of doctors across the U.S. are on medical probation for reasons including drug abuse, sexual misconduct, and making careless – sometimes deadly – mistakes. But they’re still out there practicing. And good luck figuring out who they are.”
- “Some of the most egregious cases raise the question: What does it take for a doctor to have his or her license suspended or revoked?” ... “[P]atient advocate Robert E. Oshel, the former official at the NPDB, says medical boards tend to protect their own. ‘They’re run mostly by doctors, and they are often reluctant to take actions against physicians unless they get a lot of pressure, or if something comes out in the press,’ he says.”⁶⁴

***Surgeon Scorecard*, ProPublica, 2015.**

A “small share of doctors, 11 percent, accounted for about 25 percent of the complications. Hundreds of surgeons across the country had rates double and triple the national average. Every day, surgeons with the highest complication rates in our analysis are performing operations in hospitals nationwide.” Moreover, “[m]any hospitals don’t track the complication rates of individual surgeons and use that data to force improvements. And neither does the government.”⁶⁵

❖ **SEXUAL ABUSE OF PATIENTS GOES LARGELY UNPUNISHED.**

“State Boards, Regulators Paralyzed on Physician Sex Assaults,” *Medpage Today*, February 7, 2019.

- “Often, actions against a physician’s license only occur following a criminal conviction related to medical misconduct.”
- “State boards can request information on physicians too, but its use has been limited and often ignored during licensing. In 2017, 30 state boards used it fewer than 100 times, while 13 never bothered to check it once, according to numbers from the Health Resources and Service Administration.”
- “Inconsistencies across state boards can allow physicians to cross a state border, renew their license, and continue to practice, even after they have had their license revoked. Fifteen states do not share complaints with other medical boards, while 21 denote board actions taken in other states on a physician’s profile.”⁶⁶

“In California, Doctors Accused Of Sexual Misconduct Often Get Second Chances,” *Kaiser Health News*, December 14, 2018.

- “California is often cited as one of the more rigorous states in overseeing doctors. But, according to the medical board, very few sexual misconduct complaints are reported to the board in the first place, historically under 200 a year. Even fewer result in a formal accusation against a doctor. And when discipline is found to be warranted – typically in fewer than 20 cases a year – the board tends toward leniency, sometimes granting a few years of probation even in instances of severe misconduct, according to a KHN analysis of medical board records.”
- “The number of disciplinary actions taken over the decade is strikingly small given the size of California’s practicing physician population of more than 100,000.”
- “In several cases, the board granted probation knowing the doctor had been convicted of misdemeanor criminal charges stemming from sexual abuse investigations.”
- “According to the board’s disciplinary guidelines, the minimum probation period is seven years for a doctor found to have engaged in sexual misconduct – whether it is a sexual relationship with a patient, sexualized touching during exams or inappropriate sexual conversation. But those ‘minimums’ were not applied in more than half of the probation cases, according to the KHN analysis.”⁶⁷

Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank, Public Citizen, 2018.

- “[S]tate nursing boards and health care organizations are failing to protect patients from nurses who engage in sexual misconduct.”
- “Only 882 U.S. registered and licensed practical or vocational nurses have been reported to the National Practitioner Data Bank (NPDB) over nearly 14 years (from 2003 through 2016) because of sexual misconduct, according to the study – the first to analyze this national flagging system for sexual misconduct by nurses. While male nurses account for approximately 10 percent of U.S. nurses, they accounted for 63 percent of the nurses reported to the NPDB due to sexual misconduct.”
- “Sexual misconduct by nurses is reported to the NPDB only if it results in an adverse disciplinary action by state nursing boards (or, less commonly, certain entities such as hospitals) or malpractice payments. The low number of nurses reported to the NPDB because of this misconduct – despite the fact that millions of nurses worked in the profession over the study period – suggests that many nurses who commit sexual misconduct go unpunished, [lead author Azza]AbuDagga said.”
- “[N]early half of the nurses who engaged in sexual misconduct with patients that led to NPDB malpractice payment reports – 16 out of 33 – were not disciplined by state nursing boards for their misconduct, the study found.”⁶⁸

“AP Investigation: Doctors keep licenses despite sex abuse,” Associated Press, April 15, 2018.

- “[A]cross the country, most doctors accused of sexual misconduct avoid a medical license review entirely. A study last year found that two-thirds of doctors who were sanctioned by their employers or paid a settlement as the result of sex misconduct claims never faced medical board discipline.”⁶⁹
- “The lenience of penalties for sexually abusive doctors sometimes is a source of frustration even for members of the medical board who administer the discipline.... Sexually abusive physicians are not generally required to apologize or even acknowledge having acted inappropriately in order to keep their license.”⁷⁰

“New York Allowed a Sexual Predator to Practice Medicine for Decades,” Village Voice, March 29, 2018.

“A broader examination of disciplinary records shows that the [NY] state health department has allowed doctors to keep practicing even when they are repeat offenders who have admitted to misconduct ranging from fraud to sexual abuse of patients to narcotics distribution.”⁷¹

“Is your doctor a perv? In NJ, even ones who commit sex crimes can get licenses back,” *NJ 101.5 FM*, July 10, 2017.

“Attorney General Christopher S. Porrino says the [State Board of Medical Examiners] has not reinstated any revoked licenses since it instituted reforms in 2015. But a New Jersey 101.5 review of hundreds of pages of consent orders and board decisions found five cases in the last two years in which doctors’ licenses were revoked after they admitted to sexual misconduct or were convicted of sex crimes but will still be allowed to reapply for their licenses in three to 10 years.”⁷²

“Cross-Sectional Analysis of the 1039 U.S. Physicians Reported to the National Practitioner Data Bank for Sexual Misconduct, 2003–2013,” *Public Citizen*, 2016.

- “Seventy percent of the physicians with a clinical-privileges or malpractice-payment report due to sexual misconduct were not disciplined by medical boards for this problem.”⁷³
- “For victims in malpractice-payment reports, 87.4% were female,” with emotional injury being the predominant injury type.⁷⁴

“Doctors & Sex Abuse; AJC National Investigation,” *Atlanta Journal-Constitution*, 2016.

- An AJC investigation of thousands of sex abuse cases nationwide, as well as model laws identified by regulators, federal officials and patient advocates, revealed that “despite decades of warnings about legal gaps, most states still leave patients vulnerable” to sexually abusive doctors. More specifically, of the 50 states plus D.C., only Delaware managed to score above a 90 out of a possible 100 under the paper’s patient protection analysis. As for the remaining states – one merited an 80; three earned scores in the 70s; 24 states plus D.C. scored in the 60s; twelve states scored in the 50s; and 8 states scored in the 40s. Mississippi was at the bottom of the rankings, at 37 points.⁷⁵
- “The AJC found numerous examples of hospitals and medical boards failing to report disciplinary actions. What’s more, the review found that even when hospitals and medical boards file reports, they may classify violations in a way that conceals the scope of physician sexual misconduct on the very limited portion of the data bank available to the public. Because of such gaps, the AJC – in reviewing board orders, court records and news reports – found about 70 percent more physicians accused of sexual misconduct than the 466 classified as such in the public version of the data bank from 2010 to 2014.”⁷⁶

❖ **MEDICAL MALPRACTICE PAYMENTS ARE NOT ARBITRARY; THEY REVEAL NEGLIGENCE AND FORETELL FUTURE CLAIMS.**

“Physicians with Multiple Paid Medical Malpractice Claims: Are They Outliers or Just Unlucky?” Northwestern University Law School and Kellogg School of Management Professor Bernard Black, Georgetown University Law Professor David Hyman and Northwestern University Law School Post-Doctoral Research Fellow Joshua Lerner, 2018.

After examining NPDB 2006-2015 paid claims data, researchers concluded the following:⁷⁷

- “[P]ast paid med mal claims are strong predictors of future paid claims. There are in fact some outlier physicians, with multiple paid med mal claims who are responsible for a significant share of paid claims. Indeed, we find that having even *one* prior period paid claim triples the likelihood of a future claim. Once a physician – who otherwise has average state- and specialty-specific risk – has two or more prior claims over a limited time period such as three or five years, the likelihood that this was just bad luck is small. With three prior claims, that chance becomes tiny.”
- “Our findings have obvious policy implications. Although many physicians believe that med mal claims are random, we show that there are some outlier physicians who are much more claim-prone than their fellow physicians, and provide rules of thumb for identifying them, relative to a baseline risk level that allows for state-level and specialty-level variation in baseline risk.... The take-home message is simple. When it comes to med mal, past performance predicts future results.”

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2019.

- “[M]alpractice settlements are both good indicators of past negligence and good predictors of future claims. They are good indicators because both the likelihood and the size of payments correlate with the strength of the evidence of medical malpractice. They are good predictors because the number of past settlements correlates with the likelihood that more payments will be made.”⁷⁸
- “Settlements can serve as good proxies in these ways because, generally, liability insurers are willing to pay claimants and physicians are willing to consent to settlements only when good evidence of malpractice exists.”⁷⁹

“The Association between Patient Safety Indicators and Medical Malpractice Risk: Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Northwestern University Department of Economics Ph.D. Candidate Zenon Zabinski, 2013.

After studying Texas data on medical malpractice claims closed between 1988 and 2010,⁸⁰ researchers found that “higher rates of adverse patient safety events predict higher rates of paid med mal risk claims. This suggests that med mal suits – at least the suits that lead to paid claims – are not random, and that hospitals can reduce their med mal risk by improving patient safety.”⁸¹

❖ **“TORT REFORMS” KEEP LEGITIMATE CASES FROM BEING FILED.**

“Uncovering the Silent Victims of the American Medical Liability System,” Emory University Associate Law Professor Joanna Shepherd, 2014.

After conducting a national survey of attorneys to determine medical malpractice victims’ access to the civil justice system, Shepherd found “evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system.”⁸² Among Shepherd’s conclusions from the survey results and additional analysis of empirical studies:⁸³

- “As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. ...Unfortunately, most legislative reforms over the past several decades have only exacerbated the access-to-justice problem. Damage caps and other tort reforms that artificially reduce plaintiffs’ damage awards also reduce contingent fee attorneys’ expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept.”
- Private-industry claims data show that “95% of medical malpractice victims have extreme difficulty finding legal representation unless their damages are significantly larger than the typical damages for their types of injuries.”
- “Data also suggest that the problem of access to justice is worsening; half as many victims with low damage awards recovered in 2010 as they did twenty-five years earlier. The economic realities of the medical liability system are silencing a growing number of victims.”
- “Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence.”

❖ **PHYSICIANS GREATLY MISPERCEIVE THE RISK AND CONSEQUENCES OF BEING SUED; PERSONAL ASSETS NOT AT RISK.**

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2019.

- “[P]ayments rarely exceed primary carriers’ policy limits, even when jury verdicts establish that the legal value of plaintiffs’ claims is far higher.”⁸⁴
- “[W]hen the providers are independently employed physicians, insurers provide all but a minute fraction of the dollars that are paid.”
- “Even when injuries are large and the facts strongly indicate that negligence occurred, plaintiffs’ attorneys often decline requests for representation when providers carry little or no malpractice coverage.”

“Policy Limits, Payouts, and Blood Money: Medical Malpractice Settlements in the Shadow of Insurance,” University of Texas Law Professor Charles Silver et al., 2015.

- “[Out-of-pocket payments] OOPPs are rare, they rarely threaten physicians’ financial solvency, and they would be even rarer if all physicians bought the \$1 million/\$3 million policies that the conventional wisdom says they carry.”⁸⁵
- “No study has ever shown that malpractice claims threaten doctors in any state with a significant risk of insolvency.”
- “Although physicians loudly complain that they are one med mal claim away from bankruptcy, the empirical evidence paints a radically different picture. The risk of an OOPP is small – vanishingly so when a physician buys \$1 million in malpractice coverage. Physicians who choose to buy smaller malpractice policies, and thus incur somewhat higher but still tiny OOPP risk, probably have only themselves to blame if they end up having to make an OOPP.”⁸⁶

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “Many physicians seem to believe that malpractice verdicts threaten to wipe out their savings. When assessing this fear, it is appropriate to start by observing that jury trials are uncommon and that plaintiff victories are even less common. ...[M]ost malpractice cases are settled or dismissed; only about 2% of claims are tried, and at trial, providers win about 75% of the time.”⁸⁷

- “We also learned something that may surprise many readers. When payments above the policy limits were made, whether in tried or in settled cases, they almost always came from insurers. Out-of-pocket payments by physicians were extraordinarily rare, particularly when physicians had policy limits of \geq \$500,000. One might say, with only the slightest exaggeration, that physicians have effectively no personal exposure on malpractice claims (other than the obvious and unavoidable side effects of litigation, eg, the emotional and time-related costs of being deposed). Why do plaintiffs’ lawyers not pursue personal assets? Years ago, a qualitative study documented a strong social norm among malpractice lawyers against seeking “blood money” from individual physicians. Our findings buttress that account. The only physicians who should worry about personal exposure are those who grossly underinsure, and even they should not worry too much.”⁸⁸

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“A bizarre aspect of the medical malpractice reform debate is the recognition that doctors grossly misperceive the system, accompanied by recommendations to change the system to cater to their misimpressions. Rather than educate doctors about reality, one reads of proposals to change the system to cater to physicians’ misperceptions (Hermer and Brody 2010). It seems preferable to include a reasonable medical education requirement focusing on how the legal system operates in medical malpractice cases rather than to curtail the current liability system that is widely recognized as underenforcing standard-of-care norms.”⁸⁹

“Physicians’ Fears Of Malpractice Lawsuits Are Not Assuaged By Tort Reforms,” *Health Affairs*, 2010.

Doctors’ fear of lawsuits is “out of proportion to the actual risk of being sued” and enacting “tort reforms” have no impact on this phenomenon, according to an article in the September 2010 edition of *Health Affairs* by David Katz, M.D., Associate Professor of Medicine with University of Iowa Health Care (and several other authors).⁹⁰ Several explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors’ liability limits. A second possible explanation is that doctors will “exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems.” A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. They write, “Lawsuits are rare events in a physician’s career, but physicians tend to overestimate the likelihood of experiencing them.”

❖ COMPENSATION IS FOR SERIOUS INJURIES OR DEATH; HIGH VERDICTS ARE ALMOST ALWAYS SLASHED; AND PUNITIVE DAMAGES ARE EXTREMELY RARE.

Medical Malpractice in America: A 10-Year Assessment With Insights, CRICO Strategies, 2019.

- “Although occasional case results seem random or arbitrary, the primary determinant of financial damages in MPL cases is injury severity. High-severity injury cases closed more often with an indemnity payment, and those payments were, on average, four times higher than for medium and low severity cases.”
- “High-severity injuries are more likely to result in indemnity payment. The increasing cost of long term life-care plans are reflected in the average indemnity for patients with severe, but non-fatal outcomes of care.”
- “Over the 10-year study period, nearly two-thirds of obstetrics-related cases and 63% of those alleging a diagnostic error involved high-severity injuries.”
- “Indemnity was impacted most by injury severity and patient age. Death-related cases accounted for the largest amount of total indemnity, but severely-injured patients under age 40 received the highest average payment.”
- “MPL cases compensating future medical expenses for younger patients with severe permanent injuries drive indemnity costs.”
- “Patients with severe, permanent (non-fatal) injuries seek compensation – in addition to pain and suffering – to cover the health care costs and lost income of their remaining years (sometimes decades). Thus, for the 22% of cases involving a patient’s death, the average payment (\$453K) was just over half the average payment for patients with permanent severe injuries.”⁹¹

Maternal/Fetal Risks: Using Claims Analysis to Improve Outcomes, Coverys, 2019.

The insurer’s analysis of 472 obstetric-related closed claims across a five-year period (2013-2017) revealed the following:⁹²

- 80 percent of cases involved injuries with the “highest clinical severity: significant permanent (e.g., neonatal brachial plexus injury or maternal loss of fertility), major permanent (e.g., neonatal blindness or hearing impairment, maternal organ injury), grave (e.g., neonatal neurological/brain damage, hypoxic ischemic encephalopathy, or cerebral palsy), or death (of mother, baby, or both).”
- 24 percent of cases resulted in death of the baby, mother or both.

- The most common injury to mothers was future infertility (29 percent).
- The most common injury to babies was neurological/brain damage (41 percent), followed by injuries resulting in fetal demise (34 percent).
- The single largest cause of obstetrical claims was “alleged negligence during the management of labor – accounting for 40% of claims and 49% of indemnity paid.” Risks included failure to: “Recognize and act on nonreassuring fetal heart tracings”; “Monitor mother/fetus during administration of high-risk medications (e.g., oxytocin and magnesium sulfate)”; and “Recognize and act on obstetric emergencies.”

Study of Malpractice Claims Involving Children, The Doctors Company, 2019.

The med mal insurer examined over 1,200 pediatric patient claims filed against doctors that closed from 2008-2017 and found the following:

- “Brain injuries accounted for the highest percentage of claims for all age groups: neonates, 48%; first year, 36%; child, 15%; and teenager, 11%.”⁹³
- “Children in the first-year category of the claims experienced the highest death rate at 30%.”⁹⁴ Patient deaths occurred in 15 percent of claims filed for children ages one through nine, 13 percent for neonatal patients and 13 percent for teenage patients.⁹⁵
- 75 percent of neonate closed claims, 65 percent of first year closed claims, 44 percent of ages one through nine closed claims and 32 percent of teenage closed claims were for high-severity injuries.

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2019.

- “[T]rial verdicts and settlement payments grow in size as injuries become more severe and the strength of the evidence of malpractice increases.”⁹⁶
- “[A] ‘death discount’ exists, meaning that payments tend to be larger when patients sustain grave, permanent injuries than when they die.”⁹⁷
- “Juries often send deserving plaintiffs home empty-handed, and severely injured plaintiffs frequently receive smaller payments than they deserve. The more grievous the injury, the more likely and the more serious the problem of under-compensation tends to be.”⁹⁸

2018 Medical Malpractice Payout Analysis, Diederich Healthcare, 2018.

An analysis of 2017 National Practitioner Data Bank (NPDB) data revealed that death accounted for 30 percent of medical malpractice payouts, followed by “major permanent injuries” (20 percent), “significant permanent injury” (18 percent) and “quadriplegia, brain damage, lifelong care” (12 percent).⁹⁹

“Prevalence and Characteristics of Physicians Prone to Malpractice Claims,” Stanford University Professor of Medicine and Law David M. Studdert, LL.B., Sc.D., M.P.H., et al., 2016.

According to the study – which reviewed National Practitioner Data Bank consisting of 67,000 paid claims against more than 54,000 physicians from 2005 through 2014 – “[n]early one-third of the claims involved patients who died, while 54 percent related to ‘major’ or ‘significant’ physical injury.”¹⁰⁰

National Healthcare Quality and Disparities Report: Patient Safety Chartbook, Agency for Healthcare Research and Quality, 2016.

National Practitioner Data Bank data show the following:¹⁰¹

- From 2004 to 2014, “[d]eath accounted for more than one-third of harm in payments related to monitoring (49.9%), diagnosis (39.3%), medication (38.3%), and anesthesia (36.3%) allegations.”
- From 2004 to 2014, “[m]ore than half of all obstetric payments were for allegations of permanent, severe harm (57.0%).”
- From 2004 to 2014, almost 34 percent of behavioral health-related payments were for death.

“Comparison and Trends of Inpatient and Outpatient Anesthesia Claims Reported to the National Practitioner Data Bank,” University of California, Irvine School of Medicine Anesthesiologist Richard J. Kelly, M.D., J.D., M.P.H., F.C.L.M., et al., 2015.

After reviewing inpatient and outpatient anesthesia-related physician malpractice claims between 2005 and 2013 reported to the National Practitioner Data Bank, researchers found that “[o]ver 38 percent of all paid claims were for injuries resulting in death.”¹⁰² In addition, brain damage and paralysis injuries accounted for nearly 9 percent of anesthesia-related claims.¹⁰³

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “[T]he outlandish jury verdicts that attract popular attention are not at all representative and often are slashed dramatically by judicial oversight or through other means. More broadly, the overwhelming majority (> 95%) of cases are resolved, and the overwhelming majority of payouts are made as a result of voluntary settlement.”
- “There is also a well-established severity gradient: Payments increase with injury severity, with the exception of a death discount (ie, those who die receive less than those who are severely and permanently injured). Unfortunately, most patients are undercompensated, and those with the most severe injuries suffer the biggest gap between provable injuries and the amounts they recover.”
- “Using data from the Illinois Department of Insurance closed claims database from 2005 to 2008, we find that the mean payout was \$626,827 (median, \$454,060), but the amount paid was more modest for less-severe injuries. To receive more than the mean and median payout, one had to suffer at least significant permanent injury. Further, the ceiling on payouts is modest: Those who suffered grave and permanent injuries received a mean payout of only \$1.25 million and a median payout of about \$1 million.”
- “[O]bjective figures drawn from a closed claims database maintained by the Texas Department of Insurance [show] that even in a state as large as Texas (population of almost 25 million), there were only 7,650 malpractice claims per year during the pre-reform period, and tort reform caused the number of claims to decline substantially to 5,300 per year. Both pre-reform and post-reform, most (80%–85%) of these claims closed without payment. When there was a payment, it was almost always the result of a voluntary settlement; that is, trials were rare. Across all paid cases, the mean payout was \$609,000 during the prereform period and \$419,000 during the postreform period. Jury verdicts were substantially higher, but there was a significant ‘haircut’ before they were paid.”
- “Blockbuster verdicts dominate the press, but their coverage reflects their rarity. Reporters are interested in big verdicts for the same reason they are interested in airplane crashes: Both are unusual.”
- “We found that the larger the verdict, the more likely and larger the haircut because policy limits serve as a functional cap on patients’ recoveries. Stated differently, the portion of a jury award that exceeds the available insurance coverage is rarely collectible. Other studies have documented similar haircuts with large verdicts.”¹⁰⁴

American Juries: The Verdict and **“The Verdict on Juries,”** Cornell University Law Professor Valerie P. Hans and Duke University Law Professor Neil Vidmar, 2007, 2008, respectively.

- “The fact that the jury verdict is not the end of litigation is often overlooked in discussions of the role of the jury. This is especially true of medical malpractice trials.” According to the authors, “Research consistently indicates that outlier verdicts seldom withstand postverdict proceedings. The judge may reduce the award by *remittitur* (the legal term for a reduction), or the case may be appealed to a higher court at which time the award may be reduced. Perhaps most common of all, the plaintiff and the defendant negotiate a posttrial settlement that is less than the jury verdict.” In the end, the plaintiff “negotiates a settlement around the defendant’s insurance coverage.”
- For example, “[s]ome of the largest medical malpractice awards in New York that made national headlines ultimately resulted in settlements between 5 and 10 percent of the original jury verdict actually being paid.” Similarly, “Vidmar’s Illinois study found that settlements in his sample of large jury awards averaged only 43 percent of the original verdicts.”¹⁰⁵

“Do Defendants Pay What Juries Award? Post-Verdict Haircuts in Texas Medical Malpractice Cases, 1988–2003,” University of Illinois Professor of Law and Medicine David A. Hyman et al., 2007.

Research by Hyman and colleagues from the University of Texas, New York University Law School and Georgetown University Law Center shows that most med mal jury awards receive post-verdict “haircuts.”¹⁰⁶

According to the Texas data:

- “Seventy-five percent of plaintiffs received a payout less than the adjusted verdict (jury verdict plus pre-judgment and post-judgment interest), 20 percent received the adjusted verdict (within \pm 2 percent), and 5 percent received more than the adjusted verdict.”
- “Overall, plaintiffs received a mean (median) per-case haircut of 29 percent (19 percent), and an aggregate haircut of 56 percent, relative to the adjusted verdict.”
- “The larger the verdict, the more likely and larger the haircut. For cases with a positive adjusted verdict under \$100,000, 47 percent of plaintiffs received a haircut, with a mean (median) per-case haircut of 8 percent (2 percent). For cases with an adjusted verdict larger than \$2.5 million, 98 percent of plaintiffs received a haircut with a mean (median) per-case haircut of 56 percent (61 percent).”
- “Insurance policy limits are the most important factor explaining haircuts.”

- “Most cases settle, presumably in the shadow of the outcome if the case were to be tried. That outcome is not the jury award, but the actual post-verdict payout. . . . The parties surely bargain in the shadow of the jury, but in most cases, the terms of the bargain are shaped by the shadow of coverage.”
- “Because defendants rarely pay what juries award, jury verdicts alone do not provide a sufficient basis for claims about the performance of the tort system.”

❖ **MEDICAL MALPRACTICE CASES ARE NOT CLOGGING THE COURTS; JURIES RESOLVE FEW CASES AND STRONG CASES SETTLE.**

“2017 Civil Caseloads – Trial Courts: 2017 Medical Malpractice Jury Trials and Rates,” National Center for State Courts, 2018.

According to averages calculated from the most recent NCSC data (2017), the percentage of medical malpractice cases resolved through jury trial in state courts is only 6.1 percent.¹⁰⁷ This rate is consistent with NCSC data from the previous five years.¹⁰⁸

Empirical Studies, U.S. Department of Justice, 2009.

In 2005, the most recent year studied by the U.S. Department of Justice (DOJ), only 7.8 percent of medical malpractice cases were disposed of by bench or jury trial in 49 jurisdictions reporting.¹⁰⁹ Between 1996 and 2005, the number of medical malpractice trials concluded in state courts in the nation’s 75 most populous counties remained low and fairly stable, increasing by only 1.5 percent over the ten-year period.¹¹⁰

“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” Harvard School of Public Health, 2006.

The closed claims study found that only 15 percent of claims were decided by trial verdict.¹¹¹ Other research shows that 90 percent of cases are settled without jury trial, with some estimates indicating that the figure is as high as 97 percent.¹¹²

U.S. Senate Testimony, Duke University Law Professor Neil Vidmar, 2006.

- “[T]he driving force [for settlement] in most instances is whether the insurance company and their lawyers conclude, on the basis of their own internal review, that the medical provider was negligent. . . . An earlier study . . . examined 54 obstetric malpractice claims for negligence. For cases in which settlement payments were made there was general consensus among insurance company staff, medical experts and defense attorneys that some lapse in the standard of care had occurred. No payments were made in the cases in which these various reviewers decided there was no lapse in the standard of care.”¹¹³

- “[T]he most consistent theme from [insurers] was: ‘We do not settle frivolous cases!’ The insurers indicated that there are minor exceptions, but their policy on frivolous cases was based on the belief that if they ever begin to settle cases just to make them go away, their credibility will be destroyed and this will encourage more litigation.”
- “Without question the threat of a jury trial is what forces parties to settle cases. The presence of the jury as an ultimate arbiter provides the incentive to settle but the effects are more subtle than just negotiating around a figure. The threat causes defense lawyers and the liability insurers to focus on the acts that led to the claims of negligence.”

❖ **LAWSUITS FILED FOR MEDICAL NEGLIGENCE ARE NOT FRIVOLOUS YET IT IS STILL DIFFICULT FOR PATIENTS TO PREVAIL.**

“Medical Malpractice in Image-Guided Procedures: An Analysis of 184 Cases,” University of Michigan Health System Interventional Radiology-Integrated Resident Casey S. Branach, M.D., J.D., et al., 2019.

Doctors prevailed in 81.9 percent of medical malpractice cases alleging injury from image-guided procedures. According to researchers, “This figure is in accordance with previous results finding that verdicts favor the physician in approximately 80 to 90 percent of cases that proceed to jury verdict.”¹¹⁴

Empirical Studies, National Center for State Courts/U.S. Department of Justice, 2009, 2011.

- DOJ found that the plaintiff win rate for medical malpractice was only 23 percent in 2005.¹¹⁵ Juries decided against medical malpractice plaintiffs more than three-quarters of the time.¹¹⁶ Injured patients were more successful before judges, winning 50 percent of the time.¹¹⁷
- Long-term data from state trials in the nation’s 75 most populous counties show statistically significant decreases in win rates among medical malpractice plaintiffs. More specifically, the percentage of successful plaintiffs fell by 17 percent from 1996 to 2005 and by 27.7 percent from 2001 to 2005.

***American Juries: The Verdict* and “The Verdict on Juries,” Cornell University Law Professor Valerie P. Hans and Duke University Law Professor Neil Vidmar, 2007, 2008, respectively.**

- Hans and Vidmar “explored the claims of doctors . . . about unfair treatment by juries but the empirical evidence does not back them up. The notion of the pro-plaintiff jury is contradicted by many studies that show both actual and mock jurors subject plaintiffs’ evidence to strict scrutiny.”

- Interviews with North Carolina jurors who decided medical malpractice cases led Professor Vidmar to conclude that “many jurors initially viewed the plaintiffs’ claims with great skepticism. Their attitudes were expressed in two main themes. First, they said that too many people want to get something for nothing, a skeptical attitude about claiming.... Second, they expressed the belief that most doctors try to do a good job and should not be blamed for a simple human misjudgment.”¹¹⁸ Vidmar added, “Indeed, these attitudes were even expressed in some of the cases in which jurors decided for the plaintiff. One jury that gave a multimillion-dollar award for a baby with severe brain injuries was very concerned about the possible adverse effect on the doctor’s medical practice. This does not mean that in every such case jurors held these views. Sometimes, evidence of the doctor’s seemingly careless behavior caused jurors to be angry about what happened. However, even in these latter cases, the interviews indicated that the jurors had initially approached the case with open minds.”

❖ EXPERTS SAY AND DATA SHOW THAT, EVEN WITH ITS PROBLEMS, THE MEDICAL MALPRACTICE SYSTEM WORKS.

“Screening Plaintiffs and Selecting Defendants in Medical Malpractice Litigation: Evidence from Illinois and Indiana,” Northwestern University Law School and Kellogg School of Management Professor Bernard Black et al., 2018.

After analyzing “comprehensive datasets from Illinois and Indiana, covering every insured med mal claim closed in Illinois during 2000–2010 and in Indiana during 1980–2015” and conducting interviews with med mal plaintiffs’ lawyers, researchers concluded the following:¹¹⁹

- “Consistent with prior research, plaintiffs’ lawyers report turning away many of those seeking representation after a short initial meeting or phone call. Our data also suggest, and our interviews confirm, that plaintiffs’ lawyers also drop a significant number of cases that pass their initial review, when further information makes it clear the case is not worth pursuing – because damages are insufficient or uncollectable; liability is too difficult to establish; or the costs of pursuing the lawsuit exceed its expected value. Plaintiffs’ lawyers also told us that they will also drop some defendants from a case if investigation indicates that these defendants did nothing wrong or at least that the marginal expected recovery from including them is outweighed by the incremental cost of doing so.”
- “Our data suggest, and our interviews confirm, that screening does not stop when a suit is filed. In some instances, postfiling investigation reveals the case is not worth pursuing, and the plaintiffs’ lawyer will drop the case.”
- “What about the common physician perception that plaintiffs’ lawyers often sue every physician with even a remote connection to the patient? In serious cases

involving physicians only, physicians + institutions, and institutions only, there are an average of 1.5 defendants per case in Illinois and 1.8 defendants per case in Indiana. For these categories of defendants, only 4 percent of serious Illinois cases and 8 percent of serious Indiana cases have four or more defendants.”

**“Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?”
California State University, Northridge Economics Professor and Cato Institute
Adjunct Scholar Shirley Svorny, 2011.**

In an October 2011 study, Professor Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,¹²⁰

- “The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs’ attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements.”
- “The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court.”
- “Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.”
- “Critics of the medical malpractice system point to its high administrative costs. ... Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.”

**“Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,”
Harvard School of Public Health, 2006.**

The closed claims study found that legitimate claims are being paid, non-legitimate claims are generally not being paid and “portraits of a malpractice system that is stricken with frivolous litigation are overblown.”¹²¹ Among the researchers’ more significant findings:¹²²

- Sixty-three percent of the injuries were judged to be the result of error and most of those claims received compensation; on the other hand, most individuals whose claims did not involve errors or injuries received nothing.

- Eighty percent of claims involved injuries that caused significant or major disability or death. ...[D]isputing and paying for errors account for the lion's share of malpractice costs.”

❖ THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE.

“The Impact of Tort Reform and Quality Improvements on Medical Liability Claims: A Tale of 2 States,” Southern Illinois University Medical School Orthopedic Surgery Division Chief Khaled J. Saleh, M.D., et al., 2015.

A study published in the *American Journal of Medical Quality* linked quality of care improvements with a reduction in medical malpractice claims. Researchers discovered that a “drop in malpractice claims corresponded with an increase in hospitals’ quality scores,” with the decrease in claims showing a “statistically significant correlation with the increase in quality scores based on 22 Medicare measures....” As one of the report’s co-authors explained, “Clearly, the evidence shows that if you do high quality care, it is well received by patients and decreases your medicolegal costs....”¹²³

“A comprehensive obstetric patient safety program reduces liability claims and payments,” Yale School of Medicine Associate Professor of Obstetric, Gynecology and Reproductive Sciences and Chief of Obstetrics Christian M. Pettker, M.D., et al. 2014.

As reported online by the *American Journal of Obstetrics & Gynecology*, after comparing the five-year period before their patient safety program was implemented to the five-year period afterward (1998-2002 vs. 2003-2007, respectively), Yale School of Medicine researchers found “a strong association between introduction of a comprehensive obstetric patient safety initiative and a dramatic reduction in liability claims and liability payments.” Among their key findings:¹²⁴

- An estimated 95% reduction in direct liability payments and a savings of \$48.5 million over a 5-year period.
- A “consistent pattern of statistically significant trends in reduced payments and in the variability of these payments.”
- “Furthermore, during this patient safety intervention there was a 53% reduction in liability claims and lawsuits compared with the 5 years prior.”
- “The mean number of annual cases consistently dropped over the 10-year period.”
- There were absolute decreases in the severity and types of cases in each category.

- “The results from this analysis document a third benefit of initiating a comprehensive obstetric patient safety effort: possible cost savings. Although the primary motivations driving patient safety efforts are improving quality of care and eliminating harm, these data are also important for demonstrating further downstream impacts patient safety projects can have.”
- “A reduction in liability claims is likely a hallmark of an environment with improved quality. In fact, coupling these results with our prior report demonstrating reduced adverse outcomes suggest a direct association, as others have reported.”

Is Better Patient Safety Associated with Less Malpractice Activity? Evidence from California, Rand Institute for Civil Justice, 2010.

- “Our results showed a highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims.”
- “We also found that the correlation held true when we conducted similar analyses for medical specialties—specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.”
- “These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.”
- “[N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation — a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.”
- “Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.”¹²⁵

PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND “DEFENSIVE MEDICINE”

❖ STRIPPING AWAY PATIENTS’ LEGAL RIGHTS WILL NOT LOWER (AND MAY INCREASE) HEALTH CARE COSTS; “TORT REFORM” DOES NOT REDUCE MEDICAL TESTS AND PROCEDURES (“DEFENSIVE MEDICINE”).

“Damage Caps and Defensive Medicine: Reexamination with Patient Level Data,” Northwestern University Professor Bernard Black, George Washington University Associate Professor Stephen Farmer and George Washington University Assistant Research Professor Ali Moghtaderi, 2019.

- “An often proposed remedy [to “defensive medicine”] is caps on non-economic damages.... We report evidence, from a careful study with a large, patient level dataset, of a more complex and nuanced response to caps. Rates for cardiac stress tests and other imaging tests appear to rise, instead of falling, and overall as does Medicare Part B lab and radiology spending. Yet cardiac interventions do not rise, and likely fall. There is no evidence of a fall in overall Medicare spending and, consistent with a recent prior paper (Paik et al., 2017), some evidence of higher Part B spending.”
- “The heterogeneous effects from damage caps, and lack of evidence for lower overall healthcare spending, suggest that if the policy goal is to limit health-care spending, damage caps are simply the wrong tool. If the goal is to reduce physician incentives to engage in assurance behavior by ordering tests with little or no clinical value, damage caps are too blunt a tool to achieve that goal.”
- “[A] core message from our findings is that, writ large, the ‘adopt damage caps, reduce spending’ story lacks empirical support. Instead, measures to reduce overtreatment will need to be carefully targeted to particular areas of concern.”¹²⁶

“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB4,” University of Texas at Austin Law School Professor Charles Silver, Northwestern University Law School and Kellogg School of Management Professor Bernard Black and Georgetown University Law Professor David Hyman, 2019.

“[A]lthough the damage caps adopted in Texas and other states greatly reduced the volume of malpractice litigation and payouts to patients, neither in Texas nor in other states have damage caps moderated the growth of health care spending....”¹²⁷

“How Do Changes in Medical Malpractice Liability Laws Affect Health Care Spending and the Federal Budget?” Congressional Budget Office Working Paper, April 2019.

- CBO estimates that if Congress imposed an extreme menu of tort restrictions on every state, even those that are unconstitutional, federal health care savings would total a mere \$28 billion over 10 years. This is nearly half its prior estimate of \$54 billion in total health care savings.¹²⁸ Both estimates amount to a tiny 0.5 percent in savings.
- There is no evidence that five of the six extreme tort restrictions examined by CBO¹²⁹ have any impact whatsoever on health care spending.¹³⁰
- One of the six tort restrictions – a cap on attorneys’ fees, which many states currently have – would have the opposite budgetary impact than proponents suggest. Not only would this provision have no impact on federal health care spending, it would cost the government money.¹³¹
- CBO accepts the finding of other recent studies showing that imaging and testing actually *increase* after a state enacts a cap.¹³²
- Caps on non-economic damages are the only tort restriction that CBO is willing to even consider scoring. However, the effort to try to reach a precise “savings” number is convoluted. In CBO’s own words, many of its assumptions are variously described as “fundamentally untestable,” “theoretically ambiguous” and “imprecisely estimated.”¹³³

“The C-Section Epidemic: What’s Tort Reform Got To Do With It?” Rutgers Law School Professor Sabrina Safrin, 2018.

- “Although about half the states in the Union have had non-economic damage caps in place for at least eight years, our aggregate data shows that women are just as likely to give birth by cesarean section in states with damage caps as in ones without such caps. Overall, we found that women who gave birth in states with damage caps had a 33% chance of having a C-section. Women who gave birth in states without caps had a 32% chance of delivering by C-section. There is no statistical difference in these rates.”¹³⁴
- “Moreover, damage caps have not slowed the rate of increase in C-section rates. States with damage caps and those without had no statistically different rate of change in their cesarean rates.”
- “This data shows that a woman is not less likely to give birth by cesarean section in a state with damage caps than in one without. Thus, either damage caps are insufficient to address physicians’ concerns or other explanations better account for the overuse of the procedure.”

“Association of Medical Liability Reform With Clinician Approach to Coronary Artery Disease Management,” George Washington University Associate Professor of Medicine Steven A. Farmer, M.D., Ph.D., et al., 2018.

- Researchers examined more than 36,600 doctors who evaluated patients for coronary artery disease in nine states that adopted medical malpractice damages caps between 2002 and 2005 and compared them with over 39,100 doctors in 20 states without malpractice caps.¹³⁵
- Among their chief findings? “Overall testing rates didn’t change,” and though “the kind of test doctors in new-cap states ordered did change” to less invasive ones, the “researchers do note that nationally, cardiologists were beginning to move away from more intensive procedures after a large study concluded that one of those procedures, cardiac revascularization, should not be done for people whose chronic chest pain is stable. That study and others could have influenced doctors’ choices in new-cap states toward the end of their study period, which ended in 2013.”¹³⁶
- “The next question to answer: How did those patients fare? Moghtaderi said he and his colleagues are working on that. ‘This is a very relevant and important question. If physicians change their behavior, are there any consequences for the patient?’ Stanford’s [Michelle] Mello would also like to know what happened after doctors changed the way they ordered tests. ‘I think it’s plausible the reduction in some of the more intensive procedures might be beneficial,’ she said. ‘It’s also possible they might have missed some things that were not caught.’”¹³⁷

“Association of Attitudes Regarding Overuse of Inpatient Laboratory Testing With Health Care Provider Type,” Memorial Sloan Kettering Surgeon and Health-Services Researcher Benjamin R. Roman, M.D., MSHP, et al., 2017.

- “Unnecessary testing wastes money and can lead to further testing. Why does it occur? Almost 60% of medical personnel surveyed at a large academic medical center believed that hospitalized patients should have daily laboratory testing.”¹³⁸
- “Of 1,580 attending physicians, fellows, residents, physician assistants, nurse practitioners, and nurses sent surveys, 837 (53%) responded; 393 (47%) were RNs, and 80% of those nurses felt that daily laboratory testing should be done on all patients.”¹³⁹
- “Nurses strongly felt that patient safety and protection against malpractice litigation were enhanced by daily laboratory testing.”¹⁴⁰

“Residents’ self-report on why they order perceived unnecessary inpatient laboratory tests,” University of Pennsylvania Hematology/Oncology Fellow Mina S. Sedrak, M.D., M.S., et al., 2016.

Researchers surveyed internal medicine and general surgery residents at the Hospital of the University of Pennsylvania to learn why they ordered unnecessary tests. Among their findings: ¹⁴¹

- “Of the 116 respondents, 105 (90.5%) said they ordered daily labs out of habit because that’s the way they were trained.”
- “Other frequent responses were that tests were ordered because residents weren’t aware of the costs (86.2%), discomfort with diagnostic uncertainty (82.8%), and as was the case in the previous paper, concern that the attending would ask for the lab results (75.9%).”

“Overtreatment in the United States,” Brigham and Women’s Hospital Surgery Resident Heather Lyu, M.D., et al., 2017.

When AMA-affiliated doctors from a variety of specialties and practice settings were asked, “Nationally, what do you think are the top reasons for overutilization of resources, if any?” 85% of respondents cited “fear of malpractice” as the top reason for overtreatment. As the researchers pointed out, “Perceptions on the prevalence of malpractice suits, however, may be greater than the reality of the problem. Only 2-3% of patients harmed by negligence pursue litigation, of whom about half receive compensation. Paid claims have declined by nearly 50% in the last decade....”¹⁴²

“Damage Caps and Defensive Medicine, Revisited,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2017.

The authors examined health care spending trends in nine states that enacted caps during the last “hard” insurance market (2002 to 2005),¹⁴³ compared these data to other “control” states and found the following:

- “[D]amage caps do not significantly affect Medicare Part A (hospital) spending. However, caps predict 4-5% *higher* Part B [physician] spending.”¹⁴⁴
- “A core policy argument used to support adoption of damage caps, is that caps will reduce defensive medicine and thus reduce healthcare spending. For the third-wave cap adoptions, we find evidence pointing, instead, toward *higher* Medicare Part B spending.”¹⁴⁵
- “There is, at the least, no evidence that caps *reduce* healthcare spending.”¹⁴⁶

“Defensive Medicine in U.S. Spine Neurosurgery,” Brigham and Women’s Hospital Neurosurgeon Timothy R. Smith, M.D., Ph.D., M.P.H. et al., 2017.

After analyzing survey responses from members of the American Board of Neurological Surgeons, researchers concluded that “[s]tate-based medical legal environment is not a significant driver of increased defensive medicine associated with neurosurgical spine procedures.”¹⁴⁷

“Should Physicians Be Afraid of Tort Claims? Reviewing the Empirical Evidence,” Tilburg University Director of Studies and Associate Law Professor Gijs van Dijck, 2016.

- “Do tort claims, or the fear of them, result in the adoption of practices aimed at protecting against tortious liability?...An analysis of empirical studies on defensive medicine raises doubts as to whether the assumption holds true. The findings indicate that the empirical evidence is weak and that, if there is a concern about defensive practices, it seems to exist primarily in physicians’ minds.”
- “The outcomes of these studies suggest that the evidence for defensive medicine is weak at best. This applies for both studies using tort reforms as a measure of liability risk and research that uses claims history.”
- “The idea that physicians do not or hardly ever practice defensive medicine is consistent with empirical research focusing on psychiatrists, firemen, the police, and financial regulators. Studies in those fields have also shown small or no effects resulting from tortious liability.”
- “An interesting observation is that survey research does tend to produce evidence of the practice of defensive medicine. This suggests that defensive medicine merely or predominantly exists in the minds of people. Consequently, the belief physicians have with respect to medical malpractice is not necessarily related to the actual number of claims or the actual malpractice risk. This suggests there may not be a need to call for legal reforms, at least not to tackle defensive medicine issues. Perhaps it would be more meaningful to look into possibilities to change physicians’ perceptions about tort liability exposure and its effects.”¹⁴⁸

“Are chargemaster rates for imaging studies lower in states that cap noneconomic damages (tort reform)?” Temple University Medical School Radiologist Seth I. Stein, M.D., et al, 2014.

Imaging costs did not drop in states with med mal non-economic damages (NED) caps. In fact, “imaging costs in some of the states that cap NED payouts were among the highest in the nation.” For example, “California, a state with NED tort reform, was ranked among the most costly for imaging”; “the \$662 mean charge in California for a level I diagnostic and screening ultrasound was 36 percent higher than that for all states.”

In addition, “[o]ver the past decade, imaging charges in California have increased by 400 percent, they noted, despite the NED tort reform.” Similarly, Florida and Nevada, also “NED-capped states,” have experienced high imaging costs.¹⁴⁹

“The Effect of Malpractice Reform on Emergency Department Care,” RAND Corporation Adjunct Natural Scientist Daniel A. Waxman, M.D., Ph.D., et al., 2014.

- After examining 3.8 million Medicare patient records from 1,166 hospital emergency departments from 1997 to 2011 – comparing care in three states before and after they changed their emergency care standard to gross negligence with care in neighboring states that did not pass malpractice reform – researchers found that raising the legal standard for malpractice did not result in less expensive care.¹⁵⁰
- As explained in an October 15, 2014 RAND press release, the study “examined whether physicians ordered an advanced imaging study (CT or MRI scan), whether the patient was hospitalized after the emergency visit and total charges for the visit. Advanced imaging and hospitalization are among the most costly consequences of an emergency room visit, and physicians themselves have identified them as common defensive medicine practices.”¹⁵¹ The researchers discovered that “malpractice reform laws had no effect on the use of imaging or on the rate of hospitalization following emergency visits. For two of the states, Texas and South Carolina, the law did not appear to cause any reduction in charges. Relative to neighboring states, Georgia saw a small drop of 3.6 percent in average emergency room charges following its 2005 reform.”
- “Our findings suggest that malpractice reform may have less effect on costs than has been projected by conventional wisdom,” said Dr. Daniel A. Waxman, the study’s lead author. “Physicians say they order unnecessary tests strictly out of fear of being sued, but our results suggest the story is more complicated. . . . This study suggests that even when the risk of being sued for malpractice decreases, the path of least resistance still may favor resource-intensive care, at least in hospital emergency departments. . . .”

“The Relationship Between Tort Reform and Medical Utilization” Health Watch USA Chair Kevin T. Kavanagh, M.D., M.S., et al., 2013.

“The comparison of the Dartmouth Atlas Medicare Reimbursement Data with Malpractice Reform State Rankings, which are used by the PRI [Pacific Research Institute], did not support the hypothesis that defensive medicine is a driver of rising health-care costs. Additionally, comparing Medicare reimbursements, premedical and postmedical tort reform, we found no consistent effect on health-care expenditures. Together, these data indicate that medical tort reform seems to have little to no effect on overall Medicare cost savings.”¹⁵²

“Will Tort Reform Bend the Cost Curve? Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2012.

In June 2012, the *Journal of Empirical Legal Studies* published a groundbreaking study, which concluded that limiting injured patients’ legal rights will not reduce overall health-care spending.¹⁵³ Professor Black and his co-authors – David A. Hyman, University of Illinois College of Law; Myungho Paik, Northwestern University Law School; and Charles Silver, University of Texas Law School – examined Medicare spending after Texas enacted severe “tort reform” in medical malpractice cases, including “caps” on compensation for injured patients, and found no evidence of a decline in health-care utilization. Among the report’s key findings:

- Texas’s “tort reforms” did not reduce health-care spending or spending trends.
- Limiting patients’ rights have little impact on health-care spending.
- There are many reasons why “tort reform” doesn’t lower health-care spending. “One possibility is that there may not be much ‘pure’ defensive medicine – medical treatments driven solely by liability risk. If liability is only one of a number of factors that influence clinical decisions, even a large reduction in med mal risk might have little impact on health-care spending.”
- Countless explanations exist as to why U.S. health care costs are out of control.
 - “One is physician incentives to provide profitable services....A second is a political system that has thus far been unwilling to impose, for the publicly financed portion of health-care spending, the types of limits on spending that are routine in many other countries.”
 - Moreover, “[p]olitically convenient myths are hard to kill. The myth that defensive medicine is an important driver of health-care costs is convenient to politicians who claim to want to control costs, but are unwilling to take the unpopular (with physicians or the elderly) steps needed to do so. It is convenient for health-care providers, who prefer lower liability risk. It is also convenient for members of the public, who find it easy to blame lawyers and the legal system for problems that have more complex and difficult roots, and call for stronger responses.”

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“Tort reform” provides little in the way of health care savings: “One recent summary concludes that the ‘accumulation of recent evidence finding zero or small effects suggests

that it is time for policymakers to abandon the hope that tort reform can be a major element in healthcare cost control” (Paik 2012, 175).”¹⁵⁴

True Risk: Medical Liability, Malpractice Insurance And Health Care, Americans for Insurance Reform, 2009.

“In over 30 years, medical malpractice premiums and claims have never been greater than 1% of our nation’s health care costs.”¹⁵⁵

“Defensive Medicine: A Continuing Issue in Professional Liability and Patient Safety Discussions,” Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.¹⁵⁶

- “‘Defensive medicine’ by all accounts has become such a myth, a combination of surveys of interested parties and the ‘imagination’ that those parties are avoiding – or believe they are avoiding – liability through alteration of their medical practices.”
- “The cost, if any, of defensive medicine, are trivial, in comparison to the cost of health care.”
- Medical liability “acts as a guardian against under treatment, the primary concern which should now be facing policy-makers.”
- “If tort reform reduces or even eliminates sanctions associated with negligent care and activity, adverse events themselves may increase, and by a number far greater than .2, .3 or .7% of the American health care bill.”
- “The implicit hypothesis would appear to be the following: That, in contravention of good medical judgment, the basic rules of Medicare (payment only for services that are medically necessary), threats of the potential for False Claim Act (prescribing, referring, where medically unnecessary), physicians will, as a group, act in ways which are possibly contrary to the interests of their patients, certainly contrary to reimbursement and related rules, under a theory that excessive or unnecessary prescribing and referring will insulate them from medical liability. There are many more cases concerning incompetence in credentialing and privileging, negligent referral, unnecessary radiation, etc., to provide at least a counter hypothesis.”

❖ STUDIES ESTABLISHING “DEFENSIVE MEDICINE” ARE UNRELIABLE.

“Critique of February 2011 AAOS ‘Defensive Medicine’ Survey,” Columbia University Mailman School of Public Health Clinical Professor Fred Hyde, M.D., 2011.

In a widely-reported recent “survey” of 56¹⁵⁷ or 72¹⁵⁸ Pennsylvania orthopedic surgeons, respondents claim that 19.7 percent of the imaging tests they ordered were for defensive purposes – *i.e.* to avoid being sued. This supposedly amounts to 34.8 percent of total imaging costs because “the most common test was an MRI, an imaging test which costs more than a regular X-ray.”¹⁵⁹ Professor Hyde reviewed this study for CJ&D and found:

- “In searching for the actual paper containing these findings, it turns out that there is no paper, much less one peer reviewed prior to publication. Instead, this was a podium presentation by a medical student, accompanied by a faculty supervisor.”¹⁶⁰
- “The methodology, according to news and public relations reports, was this: to ask the ordering doctor whether or not he or she was ordering a test for reasons having to do with ‘defensive medicine.’”
- “However, the issues are not straightforward. For example, a moderator of the presentation suggested other possible explanations for the MRI exams. He noted that MRIs and other imaging studies are frequently ordered ‘unnecessarily’ for reasons *other than malpractice avoidance.*”
- “The moderator noted that many MRIs are required by insurers before those insurers will authorize an arthroscopy (a minimally invasive surgical procedure in which an examination and treatment of damage of the interior of a joint is performed using an arthroscope, an endoscope inserted into the joint through a small incision).
- “The insurers require the imaging study in an attempt to protect against fraud. Orthopedic surgeons believe the MRI study prior to arthroscopy to be unnecessary; this was affirmed by a show of hands in the audience for the San Diego presentation.”
- “No mention was made of the potential for fraudulent billing if the MRI studies ordered were not for the benefit of the patient. If the box checked ‘defensive’ were accompanied by a box that indicated ‘no bill to be rendered’ or ‘bill referring physician’ this would undoubtedly have been included in the report. It would be a reasonable assumption that, to the contrary, a bill was rendered to the patient or to the insurance company for the MRIs as ordered. Were the physicians really uninterested in the results of the MRI tests, and willing to risk sanction? Or did they ‘check the box’ to ‘show support’ without realizing that it might indicate a potentially fraudulent act?”

- “Appearing in Pennsylvania especially, this study should be regarded primarily as an advocacy position. This advocacy presentation has received disproportionate attention due to its timing in the context of current proposals before the Congress, not because of the credibility of the survey. The difficulty facing physicians especially in Pennsylvania concerning the cost and availability of malpractice insurance are well known, but are due to insurance issues, and not to causes directly related to tort law.”¹⁶¹

❖ “DEFENSIVE MEDICINE” IS MEDICARE FRAUD.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – *e.g.*, possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person...who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act...will be provided economically and only when, and to the extent, medically necessary.”¹⁶² “[N]o payment may be made under part A or part B for any expenses incurred for items or services...which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”¹⁶³
- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.¹⁶⁴
- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”¹⁶⁵ If the services are, to the doctor’s knowledge, not medically necessary, the claim is false.

❖ THE REAL REASONS DOCTORS MAY ORDER TOO MANY TESTS AND PROCEDURES: WORKLOAD AND REVENUE.

“Liquid gold: Pain doctors soak up profits by screening urine for drugs,” *Kaiser Health News*, November 6, 2017.

- “[S]pending on urine screens and related genetic tests quadrupled from 2011 to 2014 to an estimated \$8.5 billion a year more than the entire budget of the Environmental

Protection Agency. The federal government paid providers more to conduct urine drug tests in 2014 than it spent on the four most recommended cancer screenings combined.”¹⁶⁶

- “Urine testing has become particularly lucrative for doctors who operate their own labs. In 2014 and 2015, Medicare paid \$1 million or more for drug-related tests billed by health professionals at more than 50 pain management practices across the U.S. At a dozen practices, Medicare billings were twice that high.”
- “Thirty-one pain practitioners received 80 percent or more of their Medicare income just from urine testing, which a federal official called a ‘red flag’ that may signal overuse and could lead to a federal investigation.”

“Business Model–Related Conflict of Interests in Medicine: Problems and Potential Solutions,” UCLA Professor of Management Ian Larkin, Ph.D., and Carnegie Mellon Professor of Economics and Psychology George Loewenstein, Ph.D., 2017.

- “Fee-for-service or volume-based reimbursement, which by one estimate determines payments for nearly 90% of US physicians, provides incentives for physicians to order more and different services than those that match patient need. This can influence treatment mix, with less profitable treatments not selected in favor of more profitable ones, and can also lead to excessive use of the most profitable treatments.”¹⁶⁷
- “[P]hysicians who own or receive payments from third-party companies providing procedures as diverse as computed tomography scans, surgery, and orthopedic treatments are much more likely to order these service. Referrals for anatomic pathology services by dermatologists, gastroenterologists, and urologists substantially increase the year after physicians begin to self-refer these tests to their own laboratories.”¹⁶⁸
- Research finding large costs associated with excessive procedures “significantly understate the true financial and nonfinancial implications of these conflicts. Patients also experience nonmonetary costs from unneeded testing and procedures because nearly every medical procedure carries medical risks, has adverse effects, generates opportunity costs of patient time, and can carry psychological costs in the form of worry as well as anguish, depending on the results of the tests or procedures. These nonfinancial ancillary costs are likely several orders of magnitude greater than financial costs, yet are difficult to quantify.”¹⁶⁹

“Low-Cost, High-Volume Health Services Contribute The Most To Unnecessary Health Spending,” UCLA David Geffen School of Medicine Assistant Professor of Medicine and RAND Corporation Health Policy Scientist John N. Mafi, M.D., M.P.H., et al., 2017.

- “A team led by UCLA researchers analyzed claims data on patients in Virginia that reflected nearly all public and private payment sources, including fee-for-service

Medicare, Medicare Advantage, Medicaid, private insurance, as well as consumer out-of-pocket costs. ... Researchers found that the 5.5 million people in the database received 5.4 million of the 44 services. Of that number, 1.7 million were low value, meaning that nearly one-third of the time they were medically unnecessary,” and “1.6 million (93%) were very low cost and low cost (\$538 or less per service), compared with 119,000 (7%) that were high and very high cost (\$538 or more).”¹⁷⁰

- “As president and CEO of the Virginia Center for Health Innovation and paper co-author Beth A. Bortz explained, ‘The current economic incentives in healthcare typically reward the provision of more services, regardless of their value to the patient...’”¹⁷¹

“So Much Care It Hurts: Unneeded Scans, Therapy, Surgery Only Add To Patients’ Ills,” *Kaiser Health News*, October 23, 2017.

- An exclusive analysis for *Kaiser Health News* – which analyzed records of 4,225 breast cancer patients treated in the first half of 2017 – found that “only 48 percent of eligible breast cancer patients today get the shorter [radiation] regimen, in spite of the additional costs and inconvenience of the longer type.”¹⁷²
- “Overzealous screening for cancers of the thyroid, prostate, breast and skin, for example, leads many older people to undergo treatments unlikely to extend their lives, but which can cause needless pain and suffering, said Dr. Lisa Schwartz, a professor at the Dartmouth Institute for Health Policy and Clinical Practice. ‘It’s just bad care,’ said Dr. Rebecca Smith-Bindman, a professor at the University of California-San Francisco, whose research has highlighted the risk of radiation from unnecessary CT scans and other imaging.”
- “In surveys, some doctors blame overtreatment on financial incentives that reward physicians and hospitals for doing more. Because insurers pay doctors for each radiation session, for example, those who prescribe longer treatments earn more money, said Dr. Peter Bach, director of Memorial Sloan Kettering’s Center for Health Policy and Outcomes in New York. ‘Reimbursement drives everything,’ said economist Jean Mitchell, a professor at Georgetown University’s McCourt School of Public Policy. ‘It drives the whole health care system.’”

***Physician Owned Distributorships: An Update on Key Issues and Areas of Congressional Concern*, U.S. Senate Finance Committee Majority Staff Report, 2016.**

“Our analysis found that:¹⁷³

1. [Physician owned distributorships] (PODs) surgeons saw **significantly more** patients (24% more) than non-POD surgeons.¹⁷⁴
2. In absolute numbers, POD surgeons performed fusion surgery on **nearly twice as many patients** (91% more) as non-POD surgeons.
3. As a percentage of patients seen, POD surgeons performed surgery at a **much higher rate** (44% higher) than non-POD surgeons.

4. In absolute number, POD surgeons performed **nearly twice as many** fusion surgeries (94% more) as non-POD surgeons.

“These findings quantify, for the first time, the extent to which POD ownership influences the behavior of individual physicians.

“In view of the findings summarized in this report, the Senate Finance Committee staff has six primary concerns about PODs,” among them:

- “POD physicians face an inherent conflict of interest when they have a financial incentive to perform surgeries. This incentive may compromise a doctor’s medical judgment and place financial incentives at odds with the best interest of the patient.”
- “Overutilization may occur if physicians perform additional, more complex, or medically unnecessary surgeries to garner POD financial incentives. Analysis by the Committee and HHS OIG suggest that POD doctors are, in fact, overutilizing spinal implant products. Such overutilization results in higher costs for the entire health care system, and particularly for Medicare.”
- “As a result of potential conflicts of interest and overutilization, PODs compromise patient safety as patients receive high-risk treatment beyond what is medically warranted. Any unnecessary medical procedure increases the risk that the patient may be harmed. Committee staff has heard extremely troubling reports of POD surgeons performing revision surgery to replace previously implanted hardware with the same or nearly equivalent hardware sold by their own PODs. While surgeons may contend that they replace such hardware for purely medical reasons, they would receive a payout from installing the POD hardware. Our concerns about medically unnecessary services are especially acute in the case of seniors who, due to their age, are less physically capable of withstanding the rigors of complex, invasive spine surgery.”

“A Small Indiana Town Scarred by a Trusted Doctor,” *New York Times*, October 17, 2015.

- “In recent years, federal officials have brought several prominent cases against cardiologists and hospitals, accusing them of performing unnecessary procedures like inserting stents into coronary arteries.”¹⁷⁵
- “‘Cardiology, whether we like it or not, is generally a big moneymaker for hospitals,’ said Dr. Steven Nissen, chief of cardiovascular medicine at the Cleveland Clinic and the former president of the American College of Cardiology. ‘We are still a fee-for-service system, and that creates, in my view, misaligned incentives among some physicians to do more procedures and among some institutions, particularly in areas where there is not tight medical supervision, to turn a blind eye and enjoy the high revenue stream.’”¹⁷⁶

**“Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists,”
Johns Hopkins Assistant Professor of Medicine Henry J. Michtalik, M.D., M.P.H.,
M.H.S., et al., 2013.**

In a survey of hospital attending doctors published in *JAMA Internal Medicine*, 22 percent of physicians reported that workload led them to “order potentially unnecessary tests, procedures, consultations, or radiographs due to not having the time to assess the patient adequately in person.”¹⁷⁷ In other words, a heavy workload, not fear of lawsuits, caused them to order extra tests, etc.

“Exclusive: Medicare on drugs: 24,000 tests for 145 patients,” *Reuters*, May 29, 2014.

“Medicare paid medical providers \$457 million in 2012 for 16 million tests to detect everything from prescription narcotics to cocaine and heroin, according to the Reuters analysis. ‘In some parts of the country every doctor and his cousin is hanging out a shingle to do (addiction) treatment. There’s a tailor-made opportunity for ordering a profusion of tests instead of one,’ said Bill Mahon, former executive director of the National Health Care Anti-Fraud Association. ‘It’s like turning on a spigot of money,’ he said.”¹⁷⁸

**“Doctors Overlook Lucrative Procedures When Naming Unwise Treatments,”
Chicago Tribune and Kaiser Health News, April 14, 2014.**

- “The medical profession has historically been reluctant to condemn unwarranted but often lucrative tests and treatments that can rack up costs to patients but not improve their health and can sometimes hurt them.”
- In 2012, “medical specialty societies began publishing lists of at least five services that both doctors and patients should consider skeptically. ... Yet some of the largest medical associations selected rare services or ones that are done by practitioners in other fields and will not affect their earnings. ‘They were willing to throw someone else’s services into the arena, but not their own,’ said Dr. Nancy Morden, a researcher at the Dartmouth Institute for Health Policy & Clinical Practice in New Hampshire.”
- The American College of Cardiology “did not tackle what studies suggest is the most frequent type of overtreatment in the field: inserting small mesh tubes called stents to prop open arteries of patients who are not suffering heart attacks, rather than first prescribing medicine or encouraging a healthier lifestyle. As many as one out of eight of these stent procedures should not have been performed, according to a study in *Circulation*, the journal of the American Heart Association. At hospitals where stenting was most overused, 59 percent of stents were inappropriate, the study found.
- “Dr. Augusto Sarmiento, a former president of the academy and retired chairman of orthopedics at the University of Miami Miller Medical School, said there were more significant overused procedures the academy omitted, including replacing hips and knees when the patient’s pain is minimal and can be managed with medicine. In addition,

Sarmiento said too many surgeons operate on simple fractured collarbones, inserting metal plates, rather than letting the injury heal with the help of a sling.”¹⁷⁹

“Patients’ Costs Skyrocket; Specialists’ Incomes Soar,” *New York Times*, January 19, 2014.

- “Doctors’ charges – and the incentives they reflect – are a major factor in the nation’s \$2.7 trillion medical bill. Payments to doctors in the United States, who make far more than their counterparts in other developed countries, account for 20 percent of American health care expenses, second only to hospital costs.”
- “Many specialists have become particularly adept at the business of medicine by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures – or doing more of lucrative ones.”
- “In addition, salary figures often understate physician earning power since they often do not include revenue from business activities: fees for blood or pathology tests at a lab that the doctor owns or ‘facility’ charges at an ambulatory surgery center where the physician is an investor, for example.”¹⁸⁰

Darshak Sanghavi, M.D., Chief of Pediatric Cardiology at the University of Massachusetts Medical School, 2013.

“Studies show that doctors order a lot of questionable testing and treatment even when malpractice risks are very low.”¹⁸¹

“Deaths Linked to Cardiac Stents Rise as Overuse Seen,” *Bloomberg News*, 2013.

- For the nearly 350,000 elective-surgery patients in stable condition who have cardiac stents implanted each year, “overuse, death, injury and fraud have accompanied the devices’ use as a go-to treatment...” This was the finding of a *Bloomberg News* investigation, which examined “thousands of pages of court documents and regulatory filings, interviews with 37 cardiologists and 33 heart patients or their survivors, and more than a dozen medical studies.” According to the report, “These sources point to stent practices that underscore the waste and patient vulnerability in a U.S. health care system that rewards doctors based on volume of procedures rather than quality of care. Cardiologists get paid less than \$250 to talk to patients about stents’ risks and alternative measures, and an average of four times that fee for putting in a stent.”
- “Stenting belongs to one of the bleakest chapters in the history of Western medicine,” University of North Carolina at Chapel Hill’s Professor Nortin Hadler told *Bloomberg News*. “Cardiologists ‘are marching on’ because ‘the interventional cardiology industry has a cash flow comparable to the GDP of many countries’ and doesn’t want to lose it, he said.” Former Assistant U.S. Attorney Jamie Bennett echoed these sentiments: “There is

a huge financial incentive to increase the number of these procedures....The cases we have seen to date are just the tip of the iceberg.” As of September 26, 2013, “[a]t least five hospitals have reached settlements with the Justice Department over allegations that they paid illegal kickbacks to doctors for patient referrals to their cath labs.”¹⁸²

Spinal Devices Supplies by Physician-Owned Distributors: Overview of Prevalence and Use, Office of Inspector General, U.S. Department of Health and Human Services, 2013.

Responding to a congressional request to investigate the growth of physician-owned distributorships for spinal fusion equipment (screws, rods and plates) and their impacts on Medicare beneficiaries and federal health care programs, OIG studied Medicare billings and found that “financial incentives for doctors may be driving some of the rapid rise in spinal fusion surgery.”¹⁸³ Among the data uncovered, as reported by the *Washington Post*:

- “Nearly one in five spinal fusions sampled in the study involved equipment purchased from distributors that were co-owned by physicians”;
- “Six months after a hospital began to purchase spinal devices from a physician-owned distributorship, the number of spinal fusions performed jumped 21 percent on average, more than twice as fast as at other hospitals”;
- “Doctors who are investors in such companies stand to benefit when more spinal fusions are performed”; and
- “The average hospital performed 62 spinal fusion surgeries per 1,000 surgical patients before beginning to purchase devices from the physician-owned companies; that figure climbed to 75 spinal surgeries per 1,000 surgical patients afterward.”

After reviewing the study, Sen. Orrin G. Hatch (R-Utah), the ranking member of the Senate Finance Committee, which had requested the investigation, said, “With this report, HHS’s inspector general has produced data that clearly demonstrate a direct correlation between the perverse financial incentives created by physician-owned distributorships and the rise in these highly invasive spinal surgeries....Given the impact of these surgeries on seniors and their health, the structure of these entities needs to be further scrutinized.”¹⁸⁴

Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrant Scrutiny, U.S. Government Accountability Office, 2013.

The report, requested by bipartisan leaders in Congress, found that doctors whose practices offered IMRT – an intensive form of prostate cancer treatment that usually costs over \$31,000 – were more likely to refer patients for IMRT therapy than less expensive treatments.¹⁸⁵ More specifically,¹⁸⁶

- “The number of Medicare prostate cancer-related intensity-modulated radiation therapy (IMRT) services performed by self-referring groups increased rapidly, while declining for non-self-referring groups from 2006 to 2010.”
- “Over this period, the number of prostate cancer–related IMRT services performed by self-referring groups increased from about 80,000 to 366,000. Consistent with that growth, expenditures associated with these services and the number of self-referring groups also increased.”
- “Providers substantially increased the percentage of their prostate cancer patients they referred for IMRT after they began to self-refer. Providers that began self-referring in 2008 or 2009 – referred to as switchers – referred 54 percent of their patients who were diagnosed with prostate cancer in 2009 for IMRT, compared to 37 percent of their patients diagnosed in 2007. In contrast, providers who did not begin to self-refer – that is, non-self-referrers and providers who self-referred the entire period – experienced much smaller changes over the same period.”

**“Urologists’ Use of Intensity-Modulated Radiation Therapy for Prostate Cancer,”
Georgetown University Public Policy Institute Economist and Professor Jean M.
Mitchell, Ph.D., 2013.**

According to a comprehensive study financed by the American Society for Radiation Oncology (ASTRO) and published in the *New England Journal of Medicine*, doctors who have a financial interest in [intensity-modulated radiation therapy] IMRT are twice as likely to recommend it despite the absence of strong evidence that it would be better than less costly options.¹⁸⁷ As reported by *Reuters*, “Federal law prohibits what is known as self-referral, when doctors send patients for tests or treatment from which the physician stands to gain financially, but makes an exception for ‘in house’ services.”¹⁸⁸ Yet, “urologists are taking advantage of a loophole in federal law that doesn’t make it a conflict of interest for the doctors to benefit from such an arrangement,” the study’s author told *Reuters*.¹⁸⁹ ASTRO’s Chairwoman agreed, saying in a news release that the “study provides clear, indisputable evidence that many men are receiving unnecessary radiation therapy for their prostate cancer due to self-referral,” adding that “[w]e must end physician self-referral for radiation therapy and protect patients from this type of abuse.”¹⁹⁰

“Physician Self-Referral: Frequency of Negative Findings at MR Imaging of the Knee as a Marker of Appropriate Utilization,” Duke University Medical Center Radiology Fellow Matthew P. Lungren, M.D. et al., 2013.

After reviewing 700 referrals for knee M.R.I.s made by two physician groups (one with a financial interest in the machine, the other without), researchers found that “patients are more likely to have magnetic resonance imaging scans that indicate nothing is wrong if they are referred by a doctor who owns the machine. The scientists conclude that doctors

with a financial interest in the machines may be more likely to order M.R.I.s even when clinical findings suggest they are unnecessary.”¹⁹¹

“Hospital Chain Inquiry Cited Unnecessary Cardiac Work,” *New York Times*, August 7, 2012.

- “[U]nnecessary – even dangerous – procedures were taking place at some HCA hospitals, driving up costs and increasing profits.”
- “HCA, the largest for-profit hospital chain in the United States with 163 facilities, had uncovered evidence as far back as 2002 and as recently as late 2010 showing that some cardiologists at several of its hospitals in Florida were unable to justify many of the procedures they were performing. ... In some cases, the doctors made misleading statements in medical records that made it appear the procedures were necessary, according to internal reports.”
- “[T]he documents suggest that the problems at HCA went beyond a rogue doctor or two....”
- “Cardiology is a lucrative business for HCA, and the profits from testing and performing heart surgeries played a critical role in the company’s bottom line in recent years.”¹⁹²

“For-profit hospitals performing more C-sections,” *California Watch*, 2010.

An investigative team recently looked at C-Section rates in California, which has had a \$250,000 cap on damages since 1975. It found that from 2005-2007.¹⁹³

- “[W]omen are at least 17 percent more likely to have a cesarean section at a for-profit hospital than at one that operates as a non-profit. A surgical birth can bring in twice the revenue of a vaginal delivery.”
- “[S]ome hospitals appear to be performing more C-sections for non-medical reasons – including an individual doctor’s level of patience and the staffing schedules in maternity wards, according to interviews with health professionals.”
- “In California, hospitals can increase their revenues by 82 percent on average by performing a C-section instead of a vaginal birth....”

“The Cost of Dying: End-of-Life Care,” *60 Minutes*, 2010.

- “Last year, Medicare paid \$55 billion just for doctor and hospital bills during the last two months of patients’ lives. That’s more than the budget for the Department of Homeland Security, or the Department of Education. And it has been estimated that 20 to 30 percent of these medical expenses may have had no meaningful impact.”¹⁹⁴

- “[T]here are other incentives that affect the cost and the care patients receive. Among them: the fact that most doctors get paid based on the number of patients that they see, and most hospitals get paid for the patients they admit.... ‘So, the more M.R.I. machines you have, the more people are gonna get M.R.I. tests?’ [Steve] Kroft asked. ‘Absolutely,’ [Dr. Elliott Fisher, a researcher at the Dartmouth Institute for Health Policy] said.”¹⁹⁵

“Doctors Reap Benefits By Doing Own Tests,” *Washington Post*, 2009.

The paper obtained Wellmark Blue Cross and Blue Shield documents, which showed that in 2005, doctors at a medical clinic on the Iowa-Illinois border were ordering eight or nine CT scans a month in August and September of 2005. But after those doctors bought their own CT scanner, within seven months, those numbers ballooned by 700 percent. The *Post* did a similar analysis of the Wellmark data for doctors in the region and found that after CT scanners were purchased, the number of scans they ordered was triple that of other area doctors who hadn’t purchased such equipment. The paper also cited consistent data from the GAO and MedPac. Jean M. Mitchell, a professor for public policy and a health economist at Georgetown University, suggested that getting rid of profit-driven medicine like this “could reduce the nation’s health care bill by as much as a quarter.”¹⁹⁶

“The Cost Conundrum: What a Texas town can teach us about health care,” *New Yorker*, 2009.

The following exchange took place with a group of doctors and author, Dr. Atul Gawande:¹⁹⁷

“It’s malpractice,” a family physician who had practiced here for thirty-three years said.

“McAllen is legal hell,” the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said. Everyone thought the lawyers here were worse than elsewhere.

That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn’t lawsuits go down?

“Practically to zero,” the cardiologist admitted.

“Come on,” the general surgeon finally said. “We all know these arguments are bullshit. There is overutilization here, pure and simple.” Doctors, he said, were racking up charges with extra tests, services, and procedures.

PART 3: PHYSICIAN SUPPLY AND ACCESS TO HEALTH CARE

❖ “TORT REFORM” DOES NOT IMPROVE ACCESS TO CARE; PHYSICIAN SHORTAGES RESULT FROM FACTORS HAVING NOTHING TO DO WITH LIABILITY.

“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB4,” University of Texas at Austin Law School Professor Charles Silver, Northwestern University Law School and Kellogg School of Management Professor Bernard Black and Georgetown University Law Professor David Hyman, 2019.

- “HB 4 [a package of severe medical malpractice “tort reforms” enacted in Texas in 2003] had no measurable effect on the size of Texas’ physician population. The impact of HB 4 on Texans’ access to medical treatments is best described as both close to zero, and precisely estimated. Our findings are consistent with those from multi-state studies of the relationship between lawsuit restrictions and physician supply, including our own, which generally find no effect or small effects for particular sub-groups of physicians, such as those practicing in rural counties.”
- “[T]here was steady growth in Texas’ supply of DPC [direct patient care] physicians, both total and per capita, both before and after reform.... Texas’ supply of direct patient care physicians grew steadily, at similar rates, in both the pre- and post-reform periods, despite politician’s claims that physicians fled Texas before reform and flocked back thereafter....”
- “Texas had a lower ratio of physicians to population than most other states before reform, and has a lower ratio today.”
- “Whatever the explanation, the truth is obvious. The med mal liability insurance crisis that Texas experienced from 1999 to 2003 did not measurably stunt the growth of the state’s supply of DPC physicians, and there is no evidence that HB 4 led to a more rapid growth rate in subsequent years. Texans’ access to medical treatments, measured in terms of physicians per capita, has improved steadily both before and after reform, albeit somewhat more slowly than for the U.S. as a whole.”
- “Texas, like many other states, faces a challenge in attracting physicians to rural areas. But we found no evidence that tort reform lessened that challenge.”
- “The primary drivers of physicians’ location decisions appear to be population trends, location of the physician’s residency, job opportunities within the physician’s specialty,

lifestyle choices, and local demand for medical services, including the extent to which the population is insured. Because Texas has a large uninsured population and large areas with low population densities, its difficulty in attracting physicians (relative to other states) is likely to continue.”

- “Labor market dynamics may also make it hard for Texas to attract doctors. When employers in one state seek to attract physicians from other states, employers in target states will react, to retain their own physicians. They may offer current employees and new applicants higher compensation, shorter work weeks, longer vacations, etc. These reactions may prevent the would-be poacher from achieving its goal.”¹⁹⁸

“Damage Caps and the Labor Supply of Physicians: Evidence from the Third Reform Wave,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2016.

The authors examined physician supply in nine states that enacted caps during the last “hard” insurance market (2002 to 2005)¹⁹⁹ and compared these data to other “control” states. They found “no evidence that cap adoption leads to an increase in total patient care physicians, increases in specialties that face high liability risk (with a possible exception for plastic surgeons), nor increases in rural physicians.”²⁰⁰

“Physician Burnout: Causes, Consequences, and (?) Cures,” Texas Heart Institute Journal Associate Editor Herbert L. Fred, M.D., M.A.C.P., and Mark S. Scheid, Ph.D., 2018.

“To sum up: a loss of autonomy, overreliance on computer data, onerous rules, an asymmetric reward system, a sense of powerlessness, and EHRs that are not designed primarily for patient care have produced a climate in which more than half of all members of the field, from medical students to senior practitioners, are burned out. As a result, physicians are quitting in large numbers, further increasing the stress on those still practicing. Those burned-out physicians who remain are less able to give appropriate patient care. There appears to be no easy solution to these problems. Sorry.”²⁰¹

***The Complexities of Physician Supply and Demand: Projections from 2016-2030,* American Association of American Medical Colleges, 2018.**

- Data analysis “shows a projected shortage of between 42,600 and 121,300 physicians by the end of the next decade” triggered by “increased demand from a growing, aging population” and “physician-retirement decisions.”²⁰²
- “Changes in physician-retirement decisions could have the greatest impact on supply, and over one-third of all currently active physicians will be 65 or older within the next decade.”²⁰³

- “To address the doctor shortage, medical schools have increased class sizes by nearly 30% since 2002. Now it’s time for Congress to do its part. Funding for residency training has been frozen since 1997 and without an increase in federal support, there simply won’t be enough doctors to provide the care Americans need.”²⁰⁴

The Future of Healthcare: A National Survey of Physicians – 2018, Doctors Company, 2018.

“Over half of physician respondents plan to retire within the next five years,” a 54 percent increase from 2012 results. Why? “Doctors are considering retirement as they feel the pressure of declining reimbursements, increased administrative burden, and industry consolidation.”²⁰⁵

2018 OB-GYN Workforce, Doximity, 2018.

Data from the Centers for Medicare & Medicaid Services, board certifications and self-reported information from about 43,000 OB-GYNs demonstrate that “the growing shortage in obstetricians and gynecologists (OB-GYN) [is] due to a maturing workforce and coming retirement wave.”²⁰⁶

Survey: Young doctors still finding jobs the old-fashioned way, CompHealth, 2018.

“Survey results indicate that work/life balance, location, being close to family, and culture fit are among the most important benefits young physicians see in their current jobs. Correspondingly, poor work/life balance, stress, and inadequate compensation were top factors that would cause respondents to consider searching for a new position.”²⁰⁷

2017 New York Residency Training Outcomes, Center for Health Workforce Studies, University at Albany School of Public Health, State University of New York, 2018.

- When respondents (*i.e.*, newly trained physicians) “who had plans to leave New York were asked about the main reason for leaving, the most common reasons reported were proximity to family (29%), better salary offered outside New York (15%), better jobs in desired locations (12%), and better jobs in desired practice setting outside New York (8%).”²⁰⁸ These reasons are consistent with previous annual surveys.²⁰⁹
- Only 1% of respondents cited the category “Cost of Malpractice Insurance” as a principal reason for practicing outside New York State.²¹⁰ And as in previous years, New York’s liability laws or legal environment were not even listed.²¹¹

Texas Projections of Supply and Demand for Primary Care Physicians and Psychiatrists, 2017–2030, Texas Department of State Health Services, 2018.

“Tort reforms” have done nothing to stem the growing problem of physician supply in Texas. According to the Texas Department of State Health Services, there’s a shortage

because of continued growth in the state, with medical school enrollment and resident positions being insufficient to meet the projected demand.²¹² As a result, “the shortage of primary-care doctors over the next 12 years will grow more than 250 percent in Houston’s region and more than 67 percent throughout Texas.”²¹³

“Can the looming physician shortage be stopped?” *Medical Economics*, May 22, 2017.

- “Soft data suggests that physicians are retiring at a younger age due to regulatory burdens, and that more young physicians are opting for non-clinical careers.”²¹⁴
- “The number of physicians who are able to become qualified to practice medicine is largely controlled by the number of residency slots available to train physicians.”
- Doctors say that the impact of efforts to increase the number of residency slots available to train physicians “is not happening fast enough for underserved patients, and some physicians believe that other changes need to take place to keep physicians in practice,” such as addressing burnout, improving the physician work environment, providing better training to advanced practice providers and easing obstacles for foreign medical school graduates to have access to jobs.

“GME Funding: How to Fix the Doctor Shortage,” *Association of American Medical Colleges*, 2017.

- “Fixing the doctor shortage requires a multi-pronged approach. This includes innovations such as team-based care and better use of technology to make care more effective and efficient. AAMC-member medical schools and teaching hospitals have been leading the movement to work better in teams – with other health professionals – nurses, dentists, pharmacists and public health professionals. These institutions also are developing the new knowledge of what works in health care – not only reading the textbooks – but writing the textbooks to advance the delivery of care.”
- “Even with all of these changes, the data clearly show that reforms alone will not eliminate the doctor shortage.
- “We also need additional federal support to train at least 3,000 more doctors a year by lifting the cap on federally funded residency training positions. Lawmakers have responded with proposals in the House and Senate to increase the number of residency positions. But they must act now in order to ensure that there are enough physicians for our growing and aging population.”²¹⁵

The Complexities of Physician Supply and Demand: Projections from 2014 to 2025, Association of American Medical Colleges, 2016.

“For all specialty categories, physician retirement decisions are projected to have the greatest impact on supply, and over one-third of all currently active physicians will be 65 or older within the next decade. Physicians between ages 65 and 75 account for 11% of the active workforce, and those between ages 55 and 64 make up nearly 26% of the active workforce. Projected shortfalls for the Other Specialties category (which includes emergency medicine, neurology, pathology, and psychiatry) are particularly sensitive to retirement assumptions.”²¹⁶

2016 Survey of America's Physicians: Practice Patterns and Perspectives, Physicians Foundation, 2016.

The survey of over 17,000 physicians “identified low physician morale as the primary factor underlying the worsening shortage. The survey found that ‘physicians identify regulatory/paperwork burdens and loss of clinical autonomy’ as their primary sources of dissatisfaction. Physicians Foundation President Walker Ray commented that ‘by retiring, taking non-clinical roles or cutting back in various other ways, physicians are essentially voting with their feet and leaving the clinical workforce. This trend is to the detriment of patient access. It is imperative that all healthcare stakeholders recognize and begin to address these issues more proactively, to support physicians and enhance the medical practice environment.’”²¹⁷

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“If increasing premiums drive exit decisions, then programs alleviating premiums should have effects. But Smits et al. (2009) surveyed all obstetrical care providers in Oregon in 2002 and 2006. Cost of malpractice premiums was the most frequently cited reason for stopping maternity care. An Oregon subsidy program for rural physicians pays 80 percent of the professional liability premium for an ob/gyn and 60 percent of the premium for a family or general practitioner. Receiving a malpractice subsidy was not associated with continuing maternity services by rural physicians. Subsidized physicians were as likely as nonsubsidized physicians to report plans to stop providing maternity care services. And physician concerns in Oregon should be interpreted in light of the NCSC finding, described above, that this was a period of substantial decline of Oregon medical malpractice lawsuit filings.”²¹⁸

Dartmouth Medical School Professor of Pediatrics and Health Policy David Goodman, M.D., M.S., 2009.

Goodman is co-investigator of the highly respected Dartmouth Atlas, which analyzes and ranks health care spending and has been the basis of a lot of discussion about why certain areas of the country are so costly. In an email to the Center for Justice & Democracy, he

said: “We haven’t explicitly analyzed this, but I agree with the impression that physician supply in general bears no relationship to state tort reform, or lack thereof.”²¹⁹

“Changes In Physician Supply And Scope Of Practice During A Malpractice Crisis: Evidence From Pennsylvania,” Harvard School of Public Health Professor Michelle Mello et al., 2007.

- In April 2007, Mello and her colleagues published a study of physician supply in Pennsylvania in the peer-reviewed journal, *Health Affairs*. The authors “looked at the behavior of physicians in ‘high-risk’ specialties – practice areas such as obstetrics/gynecology and cardiology for which malpractice premiums tend to be relatively high – over the years from 1993 through 2002. They found that contrary to predictions based on the findings of earlier physician surveys, only a small percentage of these high-risk specialists reduced their scope of practice (for example, by eliminating high-risk procedures) in the crisis period, 1999-2002, when malpractice insurance premiums rose sharply.”²²⁰
- “What’s more, the proportion of high-risk specialists who restricted their practices during the crisis period was not statistically different from the proportion who did so during 1993-1998, before premiums spiked. ‘It doesn’t appear that the restrictions we did observe after 1999 were a reaction to the change in the malpractice environment,’ said Mello, the C. Boyden Gray Professor of Health Policy and Law at the Harvard School of Public Health.”²²¹

PART 4: MEDICAL MALPRACTICE INSURANCE

❖ MEDICAL MALPRACTICE INSURERS HAVE BEEN INCREDIBLY PROFITABLE IN RECENT YEARS.

MPL Industry Results Improved in 2018, But Challenges Remain, A.M. Best, 2019.

- “The U.S. medical professional liability (MPL) segment continues to produce favorable results, with better-than-average profitability for more than a decade....”
- “The property/casualty industry’s top 20 MPL writers, based on statutory direct premiums written (DPW), accounted for 69.9% of direct premium volume in 2018. DPW for AM Best’s MPL composite was up 3.2% in 2018, to \$7.4 billion. Overall earnings were boosted by higher investment gains and lower taxes.”
- “[D]espite another year of net underwriting losses, net income increased in 2018, by 55% to \$1.8 billion due to increases in net investment income and realized capital gains. The positive impact of prior-year loss reserve development on MPL business has been diminishing in recent years, but the composite’s calendar year underwriting results still benefited operating profitability for the segment.”²²²

Myriad Challenges Test the Mettle of Medical Professional Liability Writers, A.M. Best, 2018.

- “Despite a second-straight year of underwriting losses, the U.S. medical professional liability insurance sector’s net income rose 50% year over year as realized capital gains increased threefold....”²²³
- “Despite the current challenges being faced by MPL insurers, recent operating history has been favorable. The MPL composite reported a marginal net underwriting loss in 2017, even though the combined ratio improved to 100.1 from 101.6 in 2016. However, realized gains increased more than threefold, and investment income was relatively stable. As a result, net income increased to more than \$1.1 billion from \$764 million in 2016, despite the tough market dynamics and deteriorating profit margins.”²²⁴

“2017 Year-End Financial Results for Medical Professional Liability Specialty Writers Show Continued Profitability,” Medical Liability Monitor, 2018.

- “In 2017, the medical professional liability market experienced another profitable year—with increases in net income and surplus relative to 2016, driven by promising investment performance.”²²⁵

- “[T]he composite’s annual direct-written-premium declined in 2017 – as it has each year since 2006. However, the 0.5-percent decline is the smallest annual decrease during this 11-year period – a period that saw an average annual decrease of 3 percent. Moreover, the composite’s gross written premium and net written premium actually increased in 2017 by 2.6 percent and 1.6 percent, respectively. On both a gross and net written premium basis, this was the first annual increase in premium since 2006.”
- “[A]fter-tax net income reversed a six-year negative trend with a 25-percent increase over 2016. The composite’s net income of approximately \$895 million contributed to a 1.8-percent increase in policyholder surplus for the year. A slight increase in the composite’s net earned premium in 2017 was offset by a comparable increase in loss and loss adjustment expenses. This resulted in a 2017 combined ratio after dividends of 100.9 percent – compared to 100.5 percent in 2016.”
- “With underwriting performance relatively flat, it is the composite’s investment performance – specifically the capital gains taken from the soaring 2017 financial markets – that gets credit for the increase in net income. The composite’s 2017 net realized capital gains increased by more than 500 percent relative to 2016 and reached its highest level since 2010.”

Medical Professional Liability Sector: Solid Results Despite Growing Headwinds and Deteriorating Profitability, A.M. Best, 2017.

- “For more than a decade, specialty MPL insurance companies have generated some of the best underwriting and overall operating results of any sector in the U.S. property and casualty marketplace.”²²⁶
- “Profitability measures for MPL insurers have been strong and largely buoyed by the release of redundant reserves on prior accident year claims.”
- “[T]he segment was again profitable in 2016,” achieving an overall net income of \$732 million.
- “A.M. Best estimates that MPL reserves at year-end 2016 were redundant by approximately \$3.0 billion (\$2.2 billion after discount). The gradual release of these reserves should continue to favorably contribute to the segment’s positive earnings over the next few years.”

“2016 Year-End Financial Results For Medical Professional Liability Specialty Writers,” Medical Liability Monitor, 2017.

- “[I]t’s difficult to paint too bleak a financial picture for the MPL market after reporting 13-straight years of healthy bottom lines....”²²⁷

- 2016 financial results “are again quite positive and represent 13-straight years of profitability.”
- “Net income remains strong, and improving investment yields are providing a boon for [medical professional liability specialty writers’] investment income.”
- “[O]verall financial results remain profitable in 2016 – with annual after-tax net income in excess of \$640 million.”

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2016.

- “The medical professional liability insurance industry is continuing its unprecedented run of consecutive profitable years in 2016. Never before has the industry witnessed such an unbroken string of annual favorable results, many of which were very favorable.”²²⁸
- “If we apply the metaphor of sailing a ship to the medical professional liability industry, strong tailwinds and minimal waves have made for very smooth sailing during the past decade.”
- “During the last decade or so, we’ve heard more than a few industry observers prognosticate that the party will soon be over: the hard market is coming. They’ve been dead wrong.”

***U.S. Medical Professional Liability Segment Produces Ninth Straight Year of Underwriting Profit*, A.M. Best Special Report, 2015.**

The companies that specialize in medical professional liability (MPL) insurance achieved an overall underwriting profit for a ninth consecutive year in 2014... [The A.M. Best report] also finds that 2014 represented another year since 2003 of positive net income and the 11th year out of the last 12 of positive surplus growth (the outlier being 2008 due to the financial market collapse).²²⁹

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2015

“Despite the slow softening of the [Medical Professional Liability] market, the continued profitability of this line of insurance has allowed insurers to make creative use of their increased capital beyond expanding traditional underwriting of medical and healthcare professional liability.”²³⁰

“Malpractice Insurance Business is Booming in Wisconsin and Nation,” *Milwaukee Journal Sentinel*, June 28, 2014.

- “Payments made to victims of medical malpractice are down, lawsuits filed against doctors and hospitals continue to plummet, and the industry in 2013 posted an underwriting profit for the eighth straight year, according to a May report by A.M. Best

Co, an insurance company rating service. Some of the profits are even being passed on to doctors and hospitals through cuts in premium rates or dividends, the report noted.

- “‘This is a boom time for physicians,’ said Michael Matray, editor of the Medical Liability Monitor, a Chicago trade magazine that follows the medical malpractice insurance industry. ‘And the industry is making money.’
- “... ProAssurance Corp., the fourth-largest medical malpractice insurer in the country, recorded a 103% profit margin on its premiums nationwide in 2010, records filed with insurance regulators show. The company, which is based in Alabama, has continued to post extraordinary profits on its national medical malpractice business, with a 64.7% profit margin on its premiums last year, following margins of 86.4% in 2012 and 91% in 2011.
- “‘The medical liability environment has been better than expected by anyone,’ said Howard Friedman, president of the ProAssurance’s health care professional liability group...As a group, the insurers posted an after-tax profit of \$1.5 billion last year, down from \$1.7 billion in 2012, A.M. Best reported. ‘The last four, five, six years have been uncharacteristically good,’ said Brian Atchinson, president and chief executive of PIAA, a national trade group for medical malpractice insurers.”²³¹

❖ **PREMIUM SPIKES THAT DOCTORS PERIODICALLY EXPERIENCE ARE NOT CAUSED BY JUMPS IN LAWSUITS OR CLAIMS.**

“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB 4,” University of Texas at Austin Law School Professor Charles Silver, Georgetown Law School Professor David Hyman and Northwestern University Law School and Kellogg School of Management Professor Bernard Black, 2019.

- “[W]e find no evidence that the ‘smoke’ of the insurance crisis that prompted [Texas’s 2003 medical malpractice] reforms was produced by an underlying “fire” of rising liability. Measured in a variety of ways, before and during the insurance crisis, the performance of the liability system was stable.”
- “[T]here were no major changes in the frequency of med mal claims, payout per claim, total payouts, defense costs, or jury verdicts that can explain the spike in premiums for med mal liability insurance that occurred in Texas in the years before the 2003 reforms....”
- [W]e know from other studies that the biggest drivers of malpractice claims are the rate of medical mistakes and the severity of resulting injuries. These drivers depend on the volume and mix of medical services patients receive, patients’ characteristics and technological developments, all of which change slowly. There is no obvious reason why

the error rate or the claim rate should spike for an entire state. We used the [Texas Closed Claims Database] to learn whether legislatures findings [of a major jump in the frequency and severity of claims] were accurate. After careful study, we concluded they were not.”²³²

Stable Losses, Unstable Rates 2016, Americans for Insurance Reform, 2016.

- “Total payouts over the last four decades have never spiked and have generally tracked the rate of inflation. Premiums, on the other hand, sharply increased for doctors three times over the last 40 years – in the mid-1970s, in the mid-1980s, and in the early 2000s. Each time, these volcanic eruptions in medical malpractice insurance rates developed into liability insurance “crises” for doctors.”
- “[T]hose sudden “hard market” rate hikes did not track malpractice claims or payouts whatsoever. Instead, rates rose or fell in sync with the insurance “cycle,” dictated by the state of the economy and insurance industry profitability, including gains or losses experienced by the insurance industry’s bond and stock market investments.”
- “The data plainly show that “hard markets” are not caused by tort system costs. However, for political effect during each crisis period, the insurance industry falsely blamed lawsuits and the small number of injured patients who sue in court for the industry’s decision to impose severe rate hikes on doctors.”²³³

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “Because the overwhelming majority of payments to plaintiffs are the result of voluntary settlements, one must study closed claims (rather than jury verdicts) to get a full picture of what is going on. Using both federal and state closed claims databases, studies have found that both the frequency of malpractice claiming and the payments per claim were either stable or declining during the period that preceded the latest malpractice crisis, which began in 1999 to 2000.”²³⁴
- “The finding that the latest malpractice crisis was not caused by spikes in malpractice claims or payouts should not be surprising. Although hot spots can occur, the liability system primarily responds to (and lags) the frequency of serious medical injuries. Because the frequency of serious medical injuries changes slowly, the litigation rate should not be prone to dramatic spikes in claiming.”²³⁵

❖ **MEDICAL MALPRACTICE PREMIUMS REMAIN LOW (SOFT MARKET); PREMIUMS ARE A SCAPEGOAT FOR PHYSICIAN PROBLEMS INCLUDING CHANGES IN HEALTH CARE.**

MPL Industry Results Improved in 2018, But Challenges Remain, A.M. Best, 2019.

Medical malpractice insurance rates remain stable and flat, as “prolonged soft market conditions” continue.”²³⁶

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2018.

- “Looking back at *Annual Rate Surveys* from the last 10 years, holding rates flat has been the dominant position within 50 percent or more of survey observations, reflecting that rates had not changed year over year. The *2018 Annual Rate Survey* shows that there is no shift yet in the status quo.”²³⁷
- “For the latest four years, 2015 to 2018, the percentage reporting that rates remained flat is now above 70 percent – with more than 80 percent of the 2018 observations holding the line.”
- “[T]he large majority (82 percent) of responses reported that rates have remained flat between 2017 and 2018....”
- “Consistent with *Annual Rate Survey* results for the last couple of years, the differences in the rate changes among the reported specialties [Internal Medicine, General Surgery and OB/Gyn] were within less than one-half of a point of the overall change.”

Medical Professional Liability Insurance Premiums: An Overview of the Market from 2008 to 2017, American Medical Association, 2018.

- After reviewing a decade’s worth of medical malpractice premium data collected by *Medical Liability Monitor* (MLM) – “[c]onsidered the most comprehensive source for a national perspective on MPL premiums” – the AMA found that “the period between 2008 and 2017 was one of increasing stability in medical liability premiums.”²³⁸
- In other words, “more premiums stayed the same from one year to the next than in the past,” with increases in premiums being “relatively infrequent” and “relatively small (less than 10 percent)” in the last ten years.”²³⁹

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2017.

- “The cost of medical malpractice insurance dropped 1.1% for three bellwether medical specialties in 2017, which would be the 10th consecutive year of decline except for a 0.2% increase in 2015....”²⁴⁰

- “The findings belie the notion of a medical liability crisis despite the continued push by Congressional Republicans and organized medicine to cap noneconomic damages in such lawsuits and enact other tough tort reforms. Insurance premiums continue to trail inflation for many physicians, some of whom pay less in unadjusted dollars than they did in 2001.”²⁴¹

“HealthTrek: Medical malpractice claim trends in 2017,” Willis Towers Watson, June 15, 2017.

- “Overall claim severity is trending upwards annually, but in an actuarially predictable manner. These conditions indicate general stability in the legal environment and in the market for medical professional liability insurance. These trends have favorably affected lower premiums for physicians for more than 10 years.”²⁴²

Medical Professional Liability Sector: Solid Results Despite Growing Headwinds and Deteriorating Profitability, A.M. Best, 2017.

- “The MPL sector remains a highly competitive market, and base rates have been soft for some time.”²⁴³
- “Market pricing has been persistently soft....”
- “Persistently soft pricing may very well be a byproduct of excessive capital, redundant reserves, low claims frequency, and still manageable claims severity trends. These conditions are likely to persist for the near to medium term.”

The Medical Malpractice Scapegoat, Public Citizen, 2017.

- “Medical liability insurance premiums paid in 2015 were at their lowest level since (and including) 2003, the earliest year for which such data are provided by information-services company A.M. Best.”²⁴⁴
- “National medical liability premiums have fallen for nine consecutive years.”²⁴⁵

Stable Losses, Unstable Rates 2016, Americans for Insurance Reform, 2016.

- When adjusted for medical care inflation, premiums per physician are currently at their lowest level in four decades.²⁴⁶
- When adjusted by urban consumers CPI index (a more conservative inflationary adjustment), premiums are the lowest they have ever been.²⁴⁷

“Leading Republicans See A Costly Malpractice Crisis – Experts Don’t,” *Kaiser Health News*, December 30, 2016.

“Doctors are paying less for malpractice insurance than they did in 2001 – even without adjusting for inflation, according to the Doctors Company, one of the nation’s largest malpractice insurers.”²⁴⁸

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2016.

- “According to just-released data from the 2016 Medical Liability Monitor Annual Rate Survey, the medical malpractice insurance industry’s premiums remain essentially flat, experiencing only a very slight (0.1 percent) cumulative decrease from last year across the industry.”²⁴⁹
- “For the vast majority (75 percent) of insurers in the survey, rates remained the same between 2015 and 2016, slightly higher than the percentage with no manual change shown between 2014 and 2015 (71 percent).”
- “The stability of medical malpractice premium rates is a stark contrast to the tumult occurring in other segments of the U.S. healthcare delivery system as a result of the reforms spurred by the Affordable Care Act,” said Michael Matray, editor of *Medical Liability Monitor*. “A full three quarters of the respondents to our Survey reported no rate changes in the last year, and just under 80 percent of respondents said they believe market is neither hardening or softening. Only 20 percent of respondents felt the market is getting softer, down from 43 percent who felt rates would continue to deflate last year.”

“State of the Medical Professional Malpractice Liability Insurance Market,” A.M. Best Webinar, 2016.

Richard Anderson, The Doctors Company: One thing industry has always done is to overestimate the duration of hard market and underestimate the duration of the soft markets. Most companies are still profitable today. The industry is better capitalized than at any point in history. He believes the market will stay soft and will continue this way until the next decade – 2020.

“Annual Rate Survey Issue,” *Medical Liability Monitor*, 2015.

- “According to just-released data from the 2015 Medical Liability Monitor Annual Rate Survey, the medical professional liability (medical malpractice) insurance industry’s premiums experienced a slight (0.3 percent) increase, but the financial pressure necessary to harden the market remains absent.”²⁵⁰
- “While not materially different than last year’s 1.5-percent average decrease, 2015’s 0.3-percent increase is significant because it’s the first time in almost a decade that there has

been any increase in average rates,’ said Michael Matray, editor of the Medical Liability Monitor. ‘While it is significant, no one should consider the average rate increase an indicator of a hardening market. With a reserve redundancy estimated at \$3.4 billion, the medical professional liability insurance market is expected to remain soft or flat for at least another three years – if not more.’²⁵¹

- “Nationwide, internal medicine physicians saw an average rate increase of 0.6 percent, while general surgeons had a 0.2-percent average rate decrease and OB/Gyns saw their increase by an average of 0.5 percent. In other words, the market remains flat.”²⁵²
- “Significantly, 2015 is the first year since 2006 that insurers have reported more rate increases than decreases, according to the *MLM*. However, medical liability consultant Paul Greve, who coauthored the report with actuary Susan Forray at Milliman, told *Medscape Medical News* that market conditions still favor continued rate declines. Claims frequency is at a historically low level, and payments to successful plaintiffs are not skyrocketing.”²⁵³
- “‘Every time we've had a crisis with significant rate increases, and you have to go back 15 years to see this, they were always driven by claims trends,’ said Greve, executive vice president of the Willis Healthcare Practice. ‘They’re about as favorable as they’ve been in the last 40 years.’ At the same time, malpractice carriers have set aside more money in reserves than is necessary to cover future medical liability losses. They can dip into these reserves for the next few years to subsidize low premiums as they compete for market share, said Greve.”²⁵⁴
- “While concerns about the soft market are widespread, insurers more frequently identified healthcare consolidation as the most significant threat to market share. Fully 65 percent of respondents cited consolidation of healthcare practices as the biggest, or one of the biggest, threats to their market share.”²⁵⁵

“State of the Medical Professional Malpractice Liability Insurance Market,” A.M. Best Webinar, 2015.

- All panelists agreed that med mal rates are still extremely stable, and there is no sign the soft market [i.e. low rates] is ending anytime soon. As Healthcare Services Group President and CEO Joseph Moody put it, we have “quite a ways to go before the soft market ends. Don’t see it ending in the near future.”²⁵⁶
- One new reason premiums are down is because of a shift in physicians moving out of private practice, but also, there is strong competitive pricing (*i.e.*, an extended soft market period). PIAA called this “an historic cycle.” Go back 50 years of med mal liability coverage and there’s never been such a “sustained period of long-term results.”²⁵⁷

“Why the Medical Malpractice Crisis Persists Even When Malpractice Insurance Premiums Fall,” Suffolk University Law Professor Marc A. Rodwin et al., 2015.

“When physicians are financially squeezed they might perceive malpractice premiums to be the culprit. In fact, when a physician’s income does not grow, fails to keep up with inflation, or declines altogether, the problem is not usually due to malpractice premiums; rather, the problem is more typically due to health insurers that clamp down on the size of physician fees and deny payment for services that they deem unnecessary. Malpractice premiums can be a convenient scapegoat for frustrated physicians.”²⁵⁸

“Malpractice Premiums Drop for 6th Straight Year,” *Medscape*, October 10, 2013.

- “Collective rates for obstetrician-gynecologists, internists, and general surgeons fell on average for the sixth straight year in 2013, according to an annual premium survey released this week by *Medical Liability Monitor (MLM)*.²⁵⁹
- “The 1.7% drop in premium rates this year for the combined specialties of obstetrics-gynecology, general surgery, and internal medicine...applies more or less to each individual specialty as well.”
- According to Chad Karls, Milliman principal and consulting actuary who summarized the premium trends for *MLM*, falling premiums “reflect a roughly 50% drop in malpractice claims per physician since the liability crisis in the early 2000s that the AMA references.”
- “For proponents of tort reform, ‘the wind has been taken out of their sails a little bit,’” said Karls. “‘Premium costs are lower than what they were a decade ago.’”

❖ NEITHER “TORT REFORMS” NOR “CAPS ON DAMAGES” LOWER INSURANCE PREMIUMS FOR DOCTORS.

Premium Deceit 2016, Americans for Insurance Reform, 2016.

- During the last hard market [2002-2006], “states that enacted new limits on patients’ legal rights in medical malpractice cases (caps on damages plus other traditional tort reforms) saw an average 22.7 percent decrease in pure premiums from 2002 to the present – but states that did nothing saw a larger average drop of 29.5 percent.”²⁶⁰
- “What’s more, states that enacted only caps on damages saw an average 21.8 percent decrease in pure premiums from 2002 to the present – but the states that did nothing saw an even greater average drop of 28.9 percent.”
- “In sum, the data do not support any conclusion that limiting patients’ legal rights – including capping damages - results in lower premiums for doctors.”

Comparing Maryland and Missouri: Two states that enacted severe caps on damages in the mid-1980s, only to be hit with huge rate hikes during the subsequent hard market in the early 2000s.²⁶¹

- **Maryland.** In the mid-2000s, Maryland was called an American Medical Association (AMA) “problem state”²⁶² and a “crisis state” according to the American College of Obstetricians and Gynecologists because insurance rates had suddenly jumped.²⁶³ Yet Maryland had had a cap on non-economic damages since 1986, originally \$350,000 but later increased somewhat.²⁶⁴ Despite the cap, the state experienced premiums that “rose by more than 70 percent in the last two years.”²⁶⁵ This caused lawmakers to push for, once again, even more restrictions on patients’ rights in a special session called by the Governor in 2004 ostensibly “to combat the high cost of malpractice insurance.”²⁶⁶
- **Missouri.** It was also identified by the AMA as a so-called “crisis state,”²⁶⁷ yet had had a cap on non-economic damages since 1986. (This cap was struck down as unconstitutional in July 2012 – 26 years after its enactment.²⁶⁸) The cap started at \$350,000 and was adjusted annually for inflation, reaching \$557,000 in 2003.²⁶⁹ “New medical malpractice claims dropped 14 percent in 2003 to what the [Missouri Department of Insurance] said was a record low, and total payouts to medical malpractice plaintiffs fell to \$93.5 million in 2003, a drop of about 21 percent from the previous year.”²⁷⁰ And “[t]he National Practitioner Data Bank, a federally mandated database of malpractice claims against physicians, found that the number of paid claims in Missouri fell by about 30 percent since 1991. The insurance department’s database found that paid claims against physicians fell 42.3 percent during the same time period.”²⁷¹ *Yet doctors’ malpractice insurance premiums rose by 121 percent between 2000 and 2003.*²⁷²

Other States.²⁷³

- **Florida.** “When Gov. Jeb Bush and House Speaker Johnnie Byrd pushed through a sweeping medical malpractice overhaul bill . . . the two Republican leaders vowed in a joint statement that the bill would ‘reduce ever-increasing insurance premiums for Florida’s physicians . . . and increase physicians’ access to affordable insurance coverage.’”²⁷⁴ But, insurers soon followed up with requests to increase premiums by as much as 45 percent.
- **Mississippi.** Four months after “caps” passed, investigative news articles reported that surgeons still could not find affordable insurance and that many Mississippi doctors were still limiting their practice or walking off the job in protest.²⁷⁵
- **Nevada.** Within weeks of enactment of “caps” in the summer of 2002, two major insurance companies proclaimed that they would not reduce insurance rates for at least another year to two, if ever. The Doctors Company, a nationwide medical malpractice insurer, then filed for a 16.9 percent rate increase. Two other companies filed for 25 percent and 93 percent rate increases.²⁷⁶

- **Ohio.** Almost immediately after “tort reform” passed, all five major medical malpractice insurance companies in Ohio announced they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.²⁷⁷
- **Oklahoma.** After “caps” passed in 2003, the third-largest medical malpractice insurer in the state raised its premiums 20 percent, followed by an outrageous 105 percent rate hike in 2004.²⁷⁸ The largest insurance company, which is owned by the state medical association, requested an astounding 83 percent rate hike just after “tort reform” passed (which was approved on the condition it be phased in over three years).²⁷⁹
- **Texas.** During the 2003 campaign for Prop. 12 – the “tort reform” referendum that passed – ads promised rate cuts if caps were passed. Right after the referendum passed, major insurers requested rate hikes as high as 35 percent for doctors and 65 percent for hospitals.²⁸⁰ In April 2004, after one insurer’s rate hike request was denied, it announced it was using a legal loophole to avoid state regulation and increase premiums 10 percent without approval.²⁸¹ In a 2004 filing to the Texas Department of Insurance, GE Medical Protective revealed that the state’s non-economic damage cap would be responsible for no more than a 1 percent drop in losses.²⁸²

❖ **INDUSTRY INSIDERS HAVE SAID THAT CAPPING DAMAGES WILL NOT LOWER INSURANCE RATES.**

- **American Insurance Association:** “[T]he insurance industry never promised that tort reform would achieve specific premium savings.”²⁸³
- **Sherman Joyce, President, American Tort Reform Association:** “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.”²⁸⁴
- **Victor Schwartz, General Counsel, American Tort Reform Association:** “[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’”²⁸⁵
- **State Farm Insurance Company (Kansas):** “[W]e believe the effect of tort reform on our book of business would be small. ... [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses....”²⁸⁶
- **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as “full-fledged tort reform,” including a \$450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida’s tort reforms would not effect Aetna’s rates. Aetna explained that “the review of the actual data submitted on these cases indicated no reduction of cost.”²⁸⁷
- **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage

awards, the company said, “[O]ur proposed rate would not be measurably affected by the tort reform legislation.”²⁸⁸

- **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, “it does not appear that the ‘tort reform’ law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the ‘tort reform’ law.”²⁸⁹
- **Vanderbilt University:** A regression analysis conducted by Vanderbilt University Economics Professor Frank Sloan found that caps on economic damages enacted after the mid 1970’s insurance crisis had no effect on insurance premiums.²⁹⁰

❖ **STRONG INSURANCE REGULATORY LAWS ARE THE ONLY WAY TO CONTROL INSURANCE RATES FOR DOCTORS AND HOSPITALS.**

Comparing California and Illinois: Two states that enacted both severe caps on damages and strong insurance regulation.

CALIFORNIA

Cap. In 1975, California enacted a severe \$250,000 cap on non-economic damages, the first in the nation. This cap has greatly reduced the number of genuine malpractice cases brought in California.

- Despite the reduction of legitimate cases, between 1975 and 1988, doctors’ premiums in California increased by 450 percent, rising faster than the national average.²⁹¹
- As a result of the cap, California’s medical malpractice insurance industry became so bloated that “as little as 2 or 3 percent of premiums are used to pay claims” and “the state’s biggest medical malpractice insurer, Napa-based The Doctors Company, spent only 10 percent of the \$179 million collected in premiums on claims in 2009.” Insurance Commissioner Dave Jones said that “insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers.”²⁹²

Insurance regulation. In 1988, California voters passed a stringent insurance regulatory law, Proposition 103 (Prop. 103), which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect, and allowed the public to intervene and challenge excessive rate increases.

- In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.²⁹³

- During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s, California’s regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years,²⁹⁴ saving doctors \$66 million.
- Prop. 103 has allowed the state Insurance Commissioner to take action and lower excessive insurance rates for doctors. According to an October 2012 news release issued by the California Department of Insurance,²⁹⁵
 - “Insurance Commissioner Dave Jones today announced the second medical malpractice rate reduction this year for NORCAL Mutual Insurance Company’s physician and surgeon program. The company’s 6.9 percent reduction saves primarily Southern California doctors approximately \$8.5 million annually. This company initiated rate reduction follows a Department ordered 7.1 percent decrease in March for an overall savings of \$18 million this year alone for physicians and surgeons insured by NORCAL Mutual.”
 - “Last year Commissioner Jones ordered the top six medical malpractice insurance companies in California to submit rate filings to the Department of Insurance to justify their current rates. After a thorough review of those filings, Commissioner Jones called for rate reductions. As a result of the Commissioner’s rejection of excessive rates, all six companies lowered their medical malpractice rates,” amounting to “a total savings to medical providers of \$52 million....”
 - “I’m pleased the medical malpractice rates are continuing to be decreased under the Department’s rate review process and authority,” said Commissioner Jones. “These medical malpractice rate reductions show the important role that Proposition 103, which authorizes the insurance Commissioner to reject excessive rate hikes for property and casualty insurance, including medical malpractice insurance, has played in curbing medical malpractice rates since it was passed in 1988.”

ILLINOIS

In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients (\$500,000 for doctors and \$1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down this cap as unconstitutional.²⁹⁶ Because of a non-severability clause, the insurance regulatory law was struck down, as well. In the five years these laws were in place, the following occurred:

Cap. The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said:

“It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court’s decision in *Lebron* was fully anticipated and discounted. None of the settlements that I’ve been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. *Lebron* was a Cook County case going up, so the caps haven’t been law here for quite some time.”²⁹⁷

Insurance Regulation. The strong insurance regulatory reforms *did* take effect and had an impact.

In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway’s MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new insurance regulatory law enacted by Illinois lawmakers in 2005, and expressly not the cap on compensation for patients.²⁹⁸ The new law required malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state’s Division of Insurance, allowed MedPro to “set rates that are more competitive than they could have set before.”²⁹⁹

In February 2010, the Illinois Division of Insurance said:³⁰⁰

“The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department’s rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:

- **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from \$606,355,892 in 2005 to \$541,278,548 in 2008;
- **An increase in competition among companies offering medical malpractice insurance.** In 2008, 19 companies offering coverage to physicians/surgeons each collected more than \$500,000 in premiums, an increase from 14 such companies in 2005; and
- **The entry into Illinois of new companies offering medical malpractice insurance.** In 2008, five companies collected more than \$22,000,000 in combined physicians/surgeons premiums – and at least \$1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005.”³⁰¹

PART 5: PATIENT SAFETY

❖ MEDICAL ERRORS OCCUR IN ALARMING NUMBERS AND ARE EXTREMELY COSTLY.

It has been almost two decades since the Institute of Medicine's (IOM) seminal study "To Err is Human"³⁰² was published, which found that between 44,000 and 98,000 patients are killed (and many more injured) in hospitals each year due to medical errors, costing the nation between \$17 billion and \$29 billion each year. Today, researchers consider those numbers to significantly underestimate the problem, with preventable errors causing as many as 440,000 patient deaths each year.³⁰³

Hospital Safety Grade, Leapfrog Group, 2019.

After analyzing data from the Centers for Medicare and Medicaid Services, the Centers for Disease Control and Prevention, the American Hospital Association and other sources in combination with results from a Leapfrog survey of hospitals vis-à-vis 28 national performance measures, Leapfrog found that 42 percent of the over 2,600 hospitals studied merited a C, D or F safety grade.³⁰⁴ This rate is consistent with Leapfrog data from previous years.³⁰⁵

Among the study's other findings:³⁰⁶

- "Overall, an estimated 160,000 lives are lost annually from the avoidable medical errors that are accounted for in the Leapfrog Hospital Safety Grade...."
- "If all hospitals had an avoidable death rate equivalent to 'A' hospitals, 50,000 lives would have been saved, versus 33,000 lives that would have been saved by 'A' level performance in 2016."
- "Patients at 'D' and 'F' hospitals face a 92% greater risk of avoidable death."
- "Patients at 'C' hospitals on average face an 88% greater risk of avoidable death."
- "Patients at 'B' hospitals on average face a 35% greater risk of avoidable death."

Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group, Johns Hopkins University School of Medicine’s Armstrong Institute for Patient Safety and Quality Assistant Professor Matt Austin, Ph.D, and Jordan Derk, M.P.H., 2019.

Examination of Leapfrog quality ratings data revealed an estimated 161,250 avoidable deaths occurring in U.S. hospitals each year. Researchers explained that this number is likely an undercount.³⁰⁷

“Medicare trims payments to 800 hospitals, citing patient safety incidents,” Kaiser Health News, March 4, 2019.

“Eight hundred hospitals will be paid less by Medicare this year because of high rates of infections and patient injuries, federal records show. The number is the highest since the federal government launched the Hospital-Acquired Conditions (HAC) Reduction Program, created by the Affordable Care Act, five years ago. Under the program, 1,756 hospitals have been penalized at least once, a Kaiser Health News analysis found. This year, 110 hospitals are being punished for the fifth straight time.”³⁰⁸

AHRQ National Scorecard on Hospital-Acquired Conditions Updated Baseline Rates and Preliminary Results 2014–2016, Agency for Healthcare Research and Quality, 2018.

- “Hospital patients suffered an avoidable injury in 9 of every 100 patient stays in 2016, about 2.7 million times...”
- Among the avoidable injuries suffered: “a bad reaction to medication, an injury from a procedure, a fall or an infection.”
- From 2014 to 2016, there was “a jump in the numbers of bedsores and urinary tract infections in patients with catheters during that time.”³⁰⁹

“Nurses’ And Patients’ Appraisals Show Patient Safety In Hospitals Remains A Concern,” Health Affairs, 2018.

Researchers assessed safety by examining reports from over 53,000 RNs and more than 805,000 patients at 535 hospitals in four large states at two time points between 2005 and 2016. The results reflected little to no progress toward improving patient safety and preventing patient harm. Among the key findings:³¹⁰

- Over the past decade, “only 21 percent of hospitals substantially improved their clinical work environments; 71 percent made no improvements and 7 percent experienced deteriorating work environments.”

- “Where work environments deteriorated, fewer nurses (–19 percent) gave a favorable grade on patient safety.”
- “In the study, about 30% of nurses graded their own hospitals ‘unfavorably’ on measures of patient safety and infection prevention...”
- 55 percent of nurses “would not definitely recommend their hospital to a family member or friend who needed care.”
- “Patients also expressed concern about quality and safety with 30 percent reporting that they would not definitely recommend their hospital. Nearly 40 percent of patients said that they did not always receive help quickly from hospital staff, and nearly 40% reported that medications were not always explained before given.”

“Measuring performance on the Healthcare Access and Quality Index for 195 countries and territories and selected subnational locations: a systematic analysis from the Global Burden of Disease Study 2016,” GBD 2015 Healthcare Access and Quality Collaborators, 2018.

After analyzing how well the United States fared at preventing deaths from medical errors, Global health researchers gave the U.S. a 70 out of 100. More than 55 countries exceeded that score.³¹¹ These findings are consistent with data reported the previous year.³¹²

“751 Hospitals Hit With Safety Penalties For 2018,” *Kaiser Health News*, December 21, 2017.

Federal officials discovered that 751 hospitals had unacceptably high rates of avoidable patient injuries in FY 2018, triggering millions in Medicare penalties. One-third of the hospitals are repeat offenders who also faced penalties in 2017.³¹³ Conditions measured include: infections from surgeries and urinary tract catheters; rates of MRSA, bedsores, hip fractures and blood clots; and other potential unnecessary harms.³¹⁴

***Americans’ Experiences with Medical Errors and Views on Patient Safety*, NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute, 2017.**

A 2017 nationwide survey investigating Americans’ experiences with medical errors revealed the following:³¹⁵

- “Combined, 41 percent of adults in the United States have either experienced a medical error in their own care or were personally involved in a situation where a medical error was made in the care of someone close to them.”
- “One in 5 Americans say they have personally experienced a medical error while receiving health care...including 4 percent who experienced the error within the past

year, 6 percent who experienced it within the past five years, and 11 percent who experienced it more than five years ago.”

- “Beyond personally experienced errors, 31 percent of Americans report that someone else whose care they were closely involved with experienced a medical error. This includes 6 percent who were involved with an error that occurred within the past year, 10 percent who were involved with an error that occurred within the past five years, and 15 percent who were involved with an error that occurred more than five years ago.”
- Sixty-seven percent who reported experiencing an error were not informed of the mistake by a health care provider or someone else at the facility where the error happened.
- “The current study finds that a majority of self-reported errors are occurring in outpatient settings. Thirty-four percent occurred in a doctor’s office, clinic, or health center, and another 14 percent occurred in the ER.”
- “Thirty-four percent of the medical errors reported occurred in the hospital, but not the ER.”
- “Fully 73 percent say the error had a long-term or permanent impact on at least one of these aspects of the patient’s life.”
- “Twenty-seven percent of those with medical error experience say the error had a short-term effect on their physical health that lasted less than a month, 27 percent say the error had a long-term effect that lasted more than a month, and 30 percent say the error had a permanent effect on their physical health. Just 15 percent say the medical error had no effect on their physical health.”

“Inadequate hand-off communication,” Joint Commission, 2017.

“Inadequate hand-off communication is a contributing factor to adverse events, including many types of sentinel events. The Joint Commission’s sentinel event database includes reports of inadequate hand-off communication causing adverse events, including wrong-site surgery, delay in treatment, falls, and medication errors. A study released in 2016 estimated that communication failures in U.S. hospitals and medical practices were responsible at least in part for 30 percent of all malpractice claims, resulting in 1,744 deaths and \$1.7 billion in malpractice costs over five years.”³¹⁶

“Hospital Watchdog Gives Seal of Approval, Even After Problems Emerge,” *Wall Street Journal*, September 8, 2017.

- “The Joint Commission is the accrediting organization for almost 80% of U.S. hospitals, including those for veterans, the Federal Bureau of Prisons and the Indian Health Service, giving it a sweeping quasi-governmental role overseeing medical care.”
- “The Joint Commission revoked the accreditation of less than 1% of the hospitals that were out of Medicare compliance in 2014, the Journal found. In more than 30 instances, hospitals retained their full accreditation although their violations were deemed by CMS so significant they caused, or were likely to cause, a risk of serious injury or death to patients.”
- “A result is that hundreds of hospitals with safety problems could continue to display a ‘Gold Seal of Approval’ and promote their accredited status. The Joint Commission provides hospitals with an accreditation publicity kit, and a consulting arm of the organization sells ‘We Are Accredited!’ pins and stickers. A brochure it prepared for patients reads, ‘Whenever and wherever you receive health care, look for The Joint Commission Gold Seal of Approval.’”
- “The Journal found that not only did about 350 hospitals have accreditation while in violation of Medicare safety requirements in 2014, but 60% of them also had such violations in the preceding three years.”
- “In later years, when more than a third had Medicare deficiencies, these violations included instances of patients being shocked by medical equipment, sent away from emergency departments with untreated broken bones or dying after staff members didn’t respond for trauma surgery, according to a review of CMS inspection reports, state health-department data and information from HospitalInspections.org, a site run by the Association of Health Care Journalists.”³¹⁷

Medication-related Malpractice Risks: CIRCO 2016 CBS Benchmarking Report, CRICO Strategies, 2017.

An analysis of more than 28,000 medical malpractice cases asserted from 2010-2014 revealed the following:³¹⁸

- “1 in 9 malpractice cases involves a medication-related problem.”
- “49% of all medication cases involve a high-severity injury or death.”
- “32% of medication-related malpractice cases involve a patient death, compared with 18% of all other cases.”

- In more than half the medication error cases that closed with a payment, “the patient suffered a permanent significant injury (18%) or died (34%).”
- Lastly, “a 10-year analysis of 48,483 cases with loss years from 2003–2012” found that the proportion of cases with medication errors is unchanged since 2003.

Opioid Use in Acute Care, ECRI Institute, 2017.

- ECRI found that 35 percent of over 7,200 adverse events caused by opioids were linked to medication administration errors.³¹⁹
- “Issues linked to prescribing and patient monitoring were reported less frequently, but were more likely to cause patient harm, according to the report. Patient harm was reported in 1 in 5 cases that noted a level of harm.”

Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, Commonwealth Fund, 2017.

In a study comparing U.S. health care to systems in 10 other countries, U.S. patients reported the second highest rate of medical, medication or lab errors over the past two years.³²⁰

“Safety and Quality Go Hand in Hand,” Healthgrades, 2017.

- “From 2013 to 2015, 279,376 potentially preventable patient safety events took place among Medicare patients in U.S. hospitals.”³²¹
- “Nearly 75% of patient safety events occur in these four areas: 25.7% Accidental Cut, Puncture, Perforation, or Hemorrhage during medical care (*most often occur during colorectal surgeries, bowel obstruction, and small intestine surgeries*); 24.3% Collapsed Lung due to a procedure or surgery in or around the chest (*most often occur during cardiac procedures, including pacemaker implant surgeries*); 15.9% Catheter-Related Bloodstream Infections acquired at the hospital (*most often occur with cardiac and gastrointestinal surgeries*); 7.9% Pressure Sores or Bedsores acquired in the hospital (*most often occur with sepsis, pneumonia, and heart failure*).”³²²

Patient Safety Component Manual, National Healthcare Safety Network, Centers for Disease Control and Prevention, 2017.

- **Central line-associated bloodstream infections (CLABSI).** “An estimated 30,100 central line-associated bloodstream infections (CLABSI) still occur in intensive care units and wards of U.S. acute care facilities each year.”³²³

- **Ventilator-associated pneumonias (VAPs).** “In 2011, an estimated 157,000 healthcare-associated pneumonias occurred in acute care hospitals in U.S.; 39% of these pneumonias were ventilator-associated (VAP).”
- **Urinary tract infections (UTIs).** “UTIs ... account for more than 12% of infections reported by acute care hospitals.”³²⁴ “It has been estimated that each year, more than 13,000 deaths are associated with UTIs.”
- **Surgical site infections (SSIs).** “[Surgical site infections] SSIs were the most common healthcare-associated infection, accounting for 31% of all HAIs among hospitalized patients. The CDC healthcare-associated infection (HAI) prevalence survey found that there were an estimated 157,500 surgical site infections associated with inpatient surgeries in 2011.”³²⁵ “SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death. SSI is associated with a mortality rate of 3%, and 75% of SSI-associated deaths are directly attributable to the SSI.”

“Medical error – the third leading cause of death in the US,” Johns Hopkins University Professor of Surgery and Multidisciplinary Pancreatitis Center Surgical Director Martin A. Makary, M.D., M.P.H., and Department of Surgery Research Fellow Michael Daniel, 2016.

- “Analyzing medical death rate data over an eight-year period, Johns Hopkins patient safety experts have calculated that more than 250,000 deaths per year are due to medical error in the U.S. Their figure...surpasses the U.S. Centers for Disease Control and Prevention’s (CDC’s) third leading cause of death – respiratory disease, which kills close to 150,000 people per year.”³²⁶
- “10 percent of all U.S. deaths are now due to medical error.”
- “Medical errors are an under-recognized cause of death.”

“Patient Safety at the Crossroads,” National Patient Safety Foundation President and CEO Tejal K. Gandhi, M.D., M.P.H., Institute for Healthcare Improvement President Emeritus and Senior Fellow Donald M. Berwick, M.D., M.P.P., and Toronto University Centre for Quality Improvement and Patient Safety Director Kaveh G. Shojania, M.D., 2016.

- “[I]t is now clear that medical errors and injuries have much broader effects than the [Institute of Medicine’s 1999] report addressed, causing morbidity as well as mortality and leading to harms in all health settings, not just hospitals.”³²⁷
- “[R]ecent analysis suggests 13% of harms occurring in hospitals are substantial, requiring prolonged hospital stays or life-sustaining treatment or involving permanent harm or death. Moreover, harm during hospitalization likely only reflects a small proportion of harm because substantially more care is provided in the ambulatory environment.”³²⁸

National Healthcare Quality and Disparities Report: Patient Safety Chartbook, Agency for Healthcare Research and Quality, 2016.

- **Hospital-acquired conditions (HACs).** “Hospital-acquired conditions (HACs) are conditions that patients did not have upon hospital admission, but which developed during the patient’s hospital stay. They can lead to poor patient outcomes and increased spending on health care. HACs are often preventable.” In 2014, “the overall HAC rate was 121 per 1,000 hospital discharges. Adverse drug events (41.4 per 1,000 hospital discharges) accounted for 34.2% of total HACs and pressure ulcers (30.9 per 1,000 hospital discharges) accounted for 25.5% of the total.”³²⁹
- **Healthcare-associated infections (HAIs).** “Infections acquired during a hospital stay are among the most common complications of hospital care. On any given day, about 1 in 25 hospital patients has at least one healthcare-associated infection. HAIs often increase the patient’s length of stay in the hospital, risk of mortality, and hospital costs. New infections in critically ill infants, children, and other patients generally reduce their chances for recovery.” In 2013, “the postoperative sepsis rate was 14.3 per 1,000 adult discharges with an elective operating room procedure.”³³⁰

“The Uncounted,” Reuters, 2016.

- “Reuters undertook its own analysis to get an idea of how much superbug infections cost. Using national inpatient data from the federal Agency for Healthcare Research and Quality for 2013, the analysis of millions of records focused on infections from two superbugs: methicillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*. It found that an infection can add thousands of dollars to the cost of a patient’s hospital stay. The average MRSA infection added about \$11,000 per inpatient stay, while *C. difficile* added about \$5,200.”
- “In all, Reuters found that the two infections combined added about \$6 billion in charges to hospital stays nationwide in 2013. MRSA infections added about \$4.1 billion, and *C. difficile* added about \$1.9 billion.”³³¹

“Hospital-Acquired Condition Reduction Program Fiscal Year 2017 Fact Sheet,” Centers for Medicare and Medicaid Services, 2016.

Federal officials discovered that 769 hospitals had unacceptably high rates of patient injuries in FY 2017, triggering a total of \$430 million in Medicare penalties.³³²

Patient Identification, ECRI Institute, 2016.

- ECRI Institute Patient Safety Organization (PSO) “reviewed more than 7,600 wrong-patient events occurring over a 32-month period that were submitted by 181 healthcare organizations. The events are voluntarily submitted and may represent only a small percentage of all wrong-patient events occurring at the organizations.”³³³

- “Most patient identification mistakes are caught before care is provided, but the events in this report illustrate that others do reach the patient, sometimes with potentially fatal consequences. About 9% of the events led to temporary or permanent harm or even death.”
- “More than half of the failures involved either diagnostic procedures (2,824 or 36.5%) or treatment (1,710 or 22.1%). Diagnostic procedures cover laboratory medicine, pathology, and diagnostic imaging. Treatment covers medications, procedures, and transfusions.”
- “In addition to their potential to cause serious harm, patient identification errors are particularly troublesome for a number of other reasons, including: Most, if not all, wrong-patient errors are preventable.”

2016 National Patient Misidentification Report, Ponemon Institute, 2016.

- “64% of respondents say that patient misidentification happens frequently or all the time in a typical healthcare facility, which means that the industry standard reporting of a 8-10% patient misidentification rate likely underrepresents the problem.”³³⁴
- “86% of providers have witnessed or have known of a medical error due to misidentification.”³³⁵

“Hidden Agony: When The Surgeon Leaves Something Inside You,” ABC 7 New York, May 13, 2016.

“The joint commission which accredits hospitals does keep track of items left inside surgical patients, telling the I-Team it happens roughly 2,000 to 4,000 times each year in the United States.”³³⁶

“Patients Report Suffering Severe Burns From Fires During Surgery,” NBC 4 Washington, March 2, 2016.

“‘An estimated 200 to 650 surgical fires – fires that occur in, on or around a patient who is undergoing a medical or surgical procedure – occur in the U.S. annually,’ a Joint Commission spokeswoman told the I-Team.”³³⁷

“Why unique patient identifier is needed to cut errors,” Health Data Management, May 24, 2016.

- At the Workgroup for Electronic Data Interchange’s 25th Annual National Conference, College of Healthcare Information Management Executives President and CEO Russ Branzell maintained that “the problem of patient misidentification is as pervasive today as it has ever been, and he contends it directly impacts patient safety....”

- ““Somewhere in this country right now, someone is being harmed, injured or possibly killed just due to misidentification,” he warned. “That’s how grave the issue is today.””

Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report, CRICO Strategies, 2016.

An analysis of more than 23,000 medical malpractice claims and suits filed from 2009-2013 in which patients suffered some degree of harm revealed the following.³³⁸

- “Hospitals and doctors’ offices nationwide might have avoided nearly 2,000 patient deaths – and \$1.7 billion in malpractice costs – if medical staff and patients communicated better....”
- “[T]hree out of every 10 cases include at least one specific breakdown in communication.”
- “37% of all high-severity injury cases involve a communication failure.”
- “One-third of obstetrics-related malpractice cases involve communication errors. While a woman and her obstetrician or midwife may exchange considerable information leading up to labor, the preponderance of communication errors take place once labor has begun, often engaging caregivers new to the patient or unfamiliar with one another. Indeed, miscommunication among obstetrical team members is what most commonly leads to adverse outcomes and allegations of malpractice.”
- Among obstetrics cases, “56% resulted in a high-severity injury” and “23% resulted in death (maternal or fetal).” Top communication factors included: “miscommunication among providers re: patient’s condition” (37 percent), “poor documentation of clinical findings” (16 percent) and “inadequate informed consent” (8 percent).
- “Analysis of more than 7,500 surgery-related malpractice cases finds that 26 percent involved significant communication errors. In more than half of these cases, the surgical technique was not questioned, but the patient’s care was impacted by miscommunication within the surgical team – or more commonly, by inadequate communication with the patient.”
- Among surgery cases, “34% resulted in a high-severity injury” and “14% resulted in death.” Top communication factors included: “inadequate informed consent” (23 percent), “miscommunication among providers re: patient’s condition” (19 percent) and “unsympathetic response to patient complaints” (13 percent).

“Hospital-Acquired Condition Reduction Program,” Centers for Medicare & Medicaid Services, 2015.

- In 2015, the Centers for Medicare and Medicaid Services penalized 724 hospitals for the worst performance with respect to hospital-acquired conditions. In 2016, the number of hospitals facing penalties will be even higher – 758.³³⁹
- In addition, “[m]ore than half of the hospitals that Medicare will penalize in 2016 for having the worst performance on measures of preventing patient harm are on that list for the second year in a row.”³⁴⁰

“Published Costs of Medication Errors Leading to Preventable Adverse Drug Events in Hospitals,” Cleveland Clinic Nursing Research and Innovation Office Associate Chief Nursing Officer Nancy M. Albert, Ph.D., C.C.N.S., C.H.F.N., C.C.R.N., N.E.-B.C., F.A.H.A., F.C.C.M., F.A.A.N., et al., 2015.

A survey of research related to the incidence or economic impact of preventable adverse drug events (pADESs) arising from all medication errors showed the extent to which pADEs have been a costly, long-standing problem.³⁴¹

Cost of Preventable ADEs Associated with Medication Errors³⁴²

- **2012 study.** National cost estimate – “\$2.8–5.2 billion annually with injectable medication errors.”
- **2010 study.** National cost estimate – “\$620 million for preventable adverse events due to medication errors annually.”
- **1999 study.** Cost estimate in study states – “\$308M for preventable adverse events. Extrapolate to US: \$26 billion annually \$26 billion * 16% of preventable adverse events are drug related = \$4.16 billion.”

“Evaluation of Perioperative Medication Errors and Adverse Drug Events,” Massachusetts General Hospital Anesthesiologist and Harvard Medical School Assistant Professor Karen C. Nanji, M.D., M.P.H., et al., 2015.

In a first-of-its-kind study measuring the incidence of medication errors and adverse drug events during the period immediately before, during and right after a surgical procedure, researchers found the following:³⁴³

- “[S]ome sort of mistake or adverse event occurred in every second operation and in 5 percent of observed drug administrations.”
- “Of the almost 3,675 medication administrations in the observed operations, 193 events, involving 153 medication errors and 91 adverse drug events, were recorded

either by direct observation or by chart review. Almost 80 percent of those events were determined to have been preventable.”

- “Of all the observed adverse drug events and medication errors that could have resulted in patient harm – four of which were intercepted by operating room staff before affecting the patient – 30 percent were considered significant, 69 percent serious, and less than 2 percent life-threatening; none were fatal.”
- “The most frequently observed errors were mistakes in labeling, incorrect dosage, neglecting to treat a problem indicated by the patient’s vital signs, and documentation errors.”

“Preventing falls and fall-related injuries in health care facilities,” Joint Commission, 2015.

- “Every year in the United States, hundreds of thousands of patients fall in hospitals, with 30-50 percent resulting in injury.”³⁴⁴
- “Injured patients require additional treatment and sometimes prolonged hospital stays. In one study, a fall with injury added 6.3 days to the hospital stay.”
- “The average cost for a fall with injury is about \$14,000.”

“New Medicare data available to increase transparency on hospital utilization,” U.S. Center for Medicare and Medicaid Services, 2015.

In 2013, the second-greatest hospital Medicare expense, “\$5.6 billion, went for 398,004 cases of septicemia, or blood poisoning, often a sign of poor in-patient care.”³⁴⁵

“Deadly Infections Drive Billions in Hospital Bills to Medicare,” *Bloomberg*, June 3, 2015.

- “Life-threatening complications from bacterial infections are on the rise among hospital patients, increasing at a double-digit rate as the population ages and costing U.S. health-care programs billions of dollars a year.”³⁴⁶
- “One form of the condition, severe sepsis with a major complication, was the second most frequently billed diagnosis submitted by hospitals to Medicare in 2013, with more than 398,000 cases,” amounting to “15 percent more than in 2012 and 24 percent higher than in 2011....”
- “The three sepsis-related codes included in [the Centers for Medicare & Medicaid Services] data accounted for about \$7.2 billion of Medicare payments to hospitals, up 9.5 percent from the previous year.”

“Incidence of ‘never events’ among weekend admissions versus weekday admissions to US hospitals: national analysis,” University of Southern California Medical School Neurosurgery Clinical Instructor Frank J. Attenello, M.D., et al., 2015.

Researchers analyzed data from more than 350 million U.S. hospital admissions from 2002 to 2010 and found the following:

- “16.7 million of [inpatient hospital] stays, or about 5 percent, resulted in at least one avoidable hospital-acquired condition.”³⁴⁷
- “Falls were the most common complication, occurring in 14 million admissions and accounting for 85 percent of all hospital-acquired conditions. Pressure sores and catheter-associated urinary tract infections were also common.”³⁴⁸

“Risks Are High at Low-Volume Hospitals,” *U.S. News & World Report*, May 18, 2015.

After analyzing Medicare data, the magazine found that “as many as 11,000 deaths nationally might have been prevented from 2010 through 2012 over the three years analyzed if patients who went to the lowest-volume fifth of the hospitals had gone to the highest-volume fifth.”³⁴⁹ As *U.S. News & World Report* argued, large numbers of low-volume hospitals “continue to put patients at higher risk even after three decades of published research have demonstrated that patients are more likely to die or suffer complications when treated by doctors who only occasionally see similar patients rather than by experienced teams at hospitals with more patients and established protocols.”

“Wrong-Site Surgery, Retained Surgical Items, and Surgical Fires,” RAND Corporation Behavioral Scientist and Pardee Graduate School Professor Susanne Hempel, Ph.D., et al., 2015.

According to a comprehensive data review published in *JAMA Surgery*, every year there are an estimated 500 surgeries on the wrong body part and 5,000 surgical items unintentionally left in patients’ bodies, “which constitute too many events.”³⁵⁰

***Surgeon Scorecard*, ProPublica, 2015.**

After looking at death and complication rates for surgeons performing one of eight Medicare-covered elective procedures – knee replacement, hip replacement, gallbladder removal (laparoscopic), lumbar spinal fusion (posterior column), lumbar spinal fusion (anterior column), prostate removal, prostate resection or cervical (neck) spinal fusion – ProPublica found that 3,405 Medicare patients died during a hospital stay for elective surgery between 2009 and 2013 and over 63,000 Medicare patients were readmitted with complications during the same period.³⁵¹

“Adverse Events in Robotic Surgery: A Retrospective Study of 14 Years of FDA Data,” University of Illinois at Urbana-Champaign Engineering Professor Ravishankar K. Iyer et al., 2015.

After examining over 10,000 incident reports from the FDA spanning from 2000 to 2013, researchers found that robots used in minimally invasive surgery were involved in 144 patient deaths, 1,391 patient injuries and 8,061 device malfunctions. Among the errors reported – burnt or broken pieces of tools falling into the patient (14.7 percent), electrical sparking of instruments (10.5 percent) and robots making unintended movements (8.6 percent) – the last of which resulted in 52 injuries and two deaths. In addition, more errors were reported in complicated cardiothoracic and head and neck surgeries than during gynecology and urology procedures.³⁵²

“In Hospitals, Board Rooms Are as Important as Operating Rooms,” *New York Times Upshot Blog*, February 16, 2015.

“Several studies show that hospital boards can improve quality and can make decisions associated with reduced mortality rates. But not all boards do so,”³⁵³ even though “boards, and other hospital management, can influence care in ways that individual physicians cannot.”³⁵⁴

“In general, hospital boards do not view themselves as institutional champions of quality... Only half of boards view clinical quality as one of their top two concerns. In contrast, financial performance was a top priority for about three-quarters of hospital boards.... Troublingly, most hospitals boards can’t accurately assess their institution’s quality. There’s a Lake Wobegon effect: More than half of hospitals with low quality thought they were actually above average.”³⁵⁵

***Predicting patient survival of high-risk surgeries*, Leapfrog Group and Castlight Health Inc., 2014.**

“The chance of surviving any of four high-risk surgeries can vary by as much as 23 percent depending on what hospital patients use,” according to 2013 data from 1,500 hospitals.³⁵⁶ Among the study’s key findings³⁵⁷:

- “Pancreatectomy: This surgery to remove all or part of the pancreas has the most significant variance in survival rate by hospital, at 19 percent.”
- “Esophagectomy: Usually performed to treat cancer, an esophagectomy removes all or part of the esophagus. The average survival rate is 90 percent with a variation by hospital of 88 to 98 percent.”
- “AAA repair: A surgery to treat an enlarged abdominal aorta, the major blood vessel that supplies blood to the body, has a 13 percent variation in predicted survival rates, which range from 85.7 to 98.9 percent. This variation has increased since 2013.”

- “AVR: This heart surgery treats problems with the heart’s aortic valve, and only 17 percent of hospitals fully met Leapfrog’s standard.”

“Incidence of adverse events in an integrated US healthcare system: a retrospective observational study of 82,784 surgical hospitalizations,” Ohio State University College of Public Health Biostatistics Associate Professor Bo Lu, Ph.D., et al., 2014.

“46% to 65% of adverse events in hospitals are related to surgery, especially complex procedures.”³⁵⁸

“Fiscal Year 2015 Results for the CMS Hospital-Acquired Condition Reduction Program and Hospital Value-Based Purchasing Program,” Centers for Medicare & Medicaid Services, 2014.

In December 2014, the federal government announced that it would cut payments to roughly 724 hospitals for having high rates of infections and other patient injuries.³⁵⁹ As explained by *Kaiser Health News*, “One out of every seven hospitals in the nation will have their Medicare payments lowered by 1 percent over the fiscal year that began Oct. 1 and continues through September 2015. The health law mandates the reductions for the quarter of hospitals that Medicare assessed as having the highest rates of ‘hospital-acquired conditions,’ or HACs. These conditions include infections from catheters, blood clots, bed sores and other complications that are considered avoidable.”³⁶⁰ The penalties are estimated to total \$373 million.³⁶¹

“Multistate Point-Prevalence Survey of Health Care-Associated Infections,” Centers for Disease Control and Prevention, 2014.

- “On any given day, approximately one in 25 U.S. patients has at least one infection contracted during the course of their hospital care....”³⁶²
- In 2011, “about 721,800 infections occurred in 648,000 hospital patients.”
- “About 75,000 patients with healthcare-associated infections died during their hospitalizations.”
- “The most common healthcare-associated infections were pneumonia (22 percent), surgical site infections (22 percent), gastrointestinal infections (17 percent), urinary tract infections (13 percent), and bloodstream infections (10 percent).”

“Watch Out for Urinary Tract Infections in Hospitals,” *Consumer Reports*, 2014.

After looking at infection rates in ICUs from April 2012 through March 2013 in about 2,300 hospitals in all 50 states plus Washington, D.C., and Puerto Rico, researchers found that more than 300 hospitals had at least twice the national average number of catheter

associated urinary tract infections (CAUTIs). Why? “Researchers from Columbia University and the CDC suggest it may be in part because hospitals have not yet focused on CAUTIs to the same extent that they have other kinds of infections.” Moreover, “among hospitals that had instituted policies, only up to a quarter were following them.”³⁶³

“Retained Surgical Sponges: Findings from Incident Reports and a Cost-Benefit Analysis of Radiofrequency Technology,” University HealthSystem Consortium, 2014.

As reported by the *Washington Post*,³⁶⁴

- “While rare, ‘retained surgical items’ can cause quite a bit of harm, beyond pain and suffering: readmission, additional surgeries, abscesses, intestinal fistulas, obstructions, visceral perforations and even death.”
- “Studies estimate that this happens once in every 5,500 to 7,000 surgeries; there were 51.4 million in-patient procedures performed in 2010, according to the National Center for Health Statistics. The authors of a new study estimate that a typical hospital has two of these incidents each year.”
- “Not surprisingly, each mistake is costly. In 2007, the Centers for Medicare and Medicaid Services estimated the average price of removing one of these items at \$63,631 per hospital stay, and larger settlements in lawsuits can run from \$2 million to \$5 million.”

“Safety advocates push to curb hospital surgical fires,” *Modern Healthcare*, July 14, 2014.

- “Despite a slew of news accounts about patients being set on fire in operating rooms across the country, adoption of precautionary measures has been slow, often implemented only after a hospital experiences an accident. Advocates say it’s not clear how many hospitals have instituted the available protocols, and no national safety authority tracks the frequency of surgical fires, which are thought to injure patients in one of every three incidents.”³⁶⁵
- “About 240 surgical fires occur every year, according to rough estimates by the ECRI Institute, a not-for-profit organization that conducts research on patient-safety issues. ... The steady incidence of surgical-room fires alarms safety experts and advocates. ‘They should never happen,’ said Lisa McGiffert, director of the Safe Patient Project at the Consumers Union.”

**“Impact of Attending Physician Workload on Patient Care: A Survey of Hospitalists,”
Johns Hopkins Assistant Professor of Medicine Henry J. Michtalik, M.D., M.P.H.,
M.H.S., et al., 2013.**

A survey of hospital attending doctors published in *JAMA Internal Medicine* found that overworked hospital doctors are jeopardizing patient safety. More specifically,³⁶⁶

- “Forty percent of physicians reported that their typical inpatient census exceeded safe levels at least monthly; 36% of these reported a frequency greater than once per week.”
- “When we compared the reported workload to the estimated safe workload of individual physicians, 40% of hospitalists reported exceeding their own safe numbers.”
- “Regardless of any assistance, physicians reported that they could safely see 15 patients per shift if their effort was 100% clinical.”
- “Hospitalists frequently reported that excess workload prevented them from fully discussing treatment options, caused delay in patient admissions and/or discharges, and worsened patient satisfaction....”
- “Over 20% reported that their average workload likely contributed to patient transfers, morbidity, or even mortality.”
- “This study has significant policy implications. First, hospitals need to routinely evaluate workloads of attending physicians, create standards for safe levels of work, and develop mechanisms to maintain workloads at safe levels. Second, society needs to reduce health care costs but do so wisely. The main mechanism for reducing costs is to pay less for services, assuming that providers and institutions will increase productivity and efficiency. Hospital administrators largely respond to payment reduction by increasing workload. However, excessively increasing the workload may lead to suboptimal care and less direct patient care time, which may paradoxically increase, rather than decrease, costs.”

**“A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care,”
Patient Safety America, 2013.**

According to the report, published in the *Journal of Patient Safety*, “between 210,000 and 440,000 patients each year who go to the hospital for care suffer some type of preventable harm that contributes to their death, the study says. That would make medical errors the third-leading cause of death in America, behind heart disease, which is the first, and cancer, which is second.”³⁶⁷ Leading patient safety researchers – including Dr. Lucian Leape, Dr. David Classen and Dr. Marty Makary, have endorsed this study.³⁶⁸

“Health Care – Associated Infections,” Harvard Medical School’s Brigham and Women’s Hospital Research Associate Eyal Zimlichman, M.D., MSc, et al., 2013.

According to the study, published in *JAMA Internal Medicine*, hospital-acquired infections cost the U.S. health care system \$9.8 billion a year.³⁶⁹ As reported by *Reuters*, “Zimlichman and his team reviewed 26 studies to identify the costs associated with treating the five most common, expensive and preventable infections among hospitalized patients” and found the following:³⁷⁰

- “About 441,000 of these infections occur among hospitalized adults in the U.S. every year, for a total cost of \$9.8 billion....”
- “Surgical site infections and ventilator-associated pneumonia each accounted for about one third of the total costs. That was followed by central line bloodstream infections (about 19 percent), *C. difficile* infections (15 percent) and catheter-associated UTIs, which accounted for less than 1 percent of all costs.”
- “Bloodstream infections from central lines, which are long tubes inserted in a large vein such as in the chest or arm to deliver medication, fluids, nutrients or blood products, were the most expensive, at a cost of \$45,814 per case. Ventilator-associated pneumonia, or a lung infection that develops while a person is on a respirator, came in second, at \$40,144 per case.”
- “Post-surgery infections occurring at the site of the operation cost \$20,785 per patient. Infection with *Clostridium difficile*, a tough-to-treat bacterium that causes severe diarrhea and can spread within hospital units, cost \$11,285 per case. Catheter-associated urinary tract infections (UTIs) were the least costly, at \$896 per case.”

As Dr. Peter Pronovost, director of the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine in Baltimore, told *Reuters Health*, “This study really adds further evidence that not only are these infections too common and often lethal, they’re extremely expensive.... We really need to accelerate our efforts to reduce these infections.”³⁷¹

Sentinel Event Alert, Joint Commission, 2013.

- According to the non-profit’s report, since 2005, there have been nearly 800 incidents of surgical tools being left inside patients following a procedure. Among the objects most commonly left behind: sponges, towels, broken parts of instruments, stapler components, needles and other sharps. “These cases resulted in 16 deaths, and about 95 percent of these incidents resulted in additional care and/or an extended hospital stay,” explained the Joint Commission. “Beyond the human toll, studies have shown that objects left behind after surgery may cost as much as \$200,000 per case in medical and liability payments.”³⁷²

- Why is this happening? The study found the most common root causes are: “the absence of policies and procedures, failure to comply with existing policies and procedures, problems with hierarchy and intimidation in the surgical team, failure in communication with physicians, failure of staff to communicate relevant patient information and inadequate or incomplete staff education.”

“Surgical never events in the United States,” Johns Hopkins University School of Medicine Associate Professor of Surgery Martin Makary, M.D., M.P.H., et al., 2012.

- In a groundbreaking study of NPDB data, patient safety researchers found that 4,044 surgical “never events” (*i.e.*, surgical mistakes that should never happen) occur in the United States each year. More specifically,

“[A] surgeon in the United States leaves a foreign object such as a sponge or a towel inside a patient’s body after an operation 39 times a week, performs the wrong procedure on a patient 20 times a week and operates on the wrong body site 20 times a week.”³⁷³ In other words, an estimated “80,000 of these so-called ‘never events’ occurred in American hospitals between 1990 and 2010,” a number the researchers believe is “likely on the low side.”

- Between 1990 and 2010, the cost of malpractice payments for surgical “never events” totaled \$1.3 billion.

***Best Care at Lower Cost: The Path to Continuously Learning Health Care in America*, Institute of Medicine, 2012.**

- “More than a decade since the Institute of Medicine’s (IOM) *To Err Is Human: Building a Safer Health System* was published, the U.S. health care system continues to fall far short of its potential. . . . The nation has yet to see the broad improvements in safety, accessibility, quality, or efficiency that the American people need and deserve.”³⁷⁴
- “As the IOM committee reports, every missed opportunity for improving health care results in unnecessary suffering. By one estimate, almost 75,000 needless deaths could have been averted in 2005 if every state had delivered care on par with the best performing state. Current waste diverts resources; the committee estimates \$750 billion in unnecessary health spending in 2009 alone.”³⁷⁵ As the *New York Times* explains, “The institute’s analysis of 2009 data shows \$210 billion spent on unnecessary services, like repeated tests, and \$130 billion spent on inefficiently delivered services, like a scan performed in a hospital rather than an outpatient center.”³⁷⁶ Moreover, “It also shows the health care system wasting \$75 billion a year on fraud, \$55 billion on missed prevention opportunities and a whopping \$190 billion on paperwork and unnecessary administrative costs.”³⁷⁷

“What’s Possible for Health Care?” Institute of Medicine, 2012.

“1/3 of hospitalized patients are harmed during their stay.”³⁷⁸

***Health Affairs*, 2011.**

The April 2011 edition of *Health Affairs* contained three important articles about medical errors and their costs:

“Global Trigger Tool’ Shows That Adverse Events In Hospitals May Be Ten Times Greater Than Previously Measured,” University of Utah Associate Professor of Medicine David Classen et al.

This study found that medical errors occur in one-third of hospital admissions, as much as ten times more frequently than previously estimated.³⁷⁹ This is because adverse event detection methods commonly used to track patient safety in the United States today — voluntary reporting and the Agency for Healthcare Research and Quality’s Patient Safety Indicators — are woefully inadequate, missing as many as 90 percent of hospital errors.³⁸⁰

Chief medical mistakes uncovered in the report: “medication errors, including getting the wrong drug or being given the wrong dose of the right drug; surgical errors, such as having an operation done on the wrong site or surgical gaffes that result in bleeding or infection; and hospital-acquired infections, which often result from poor sanitation.”³⁸¹ As lead researcher Dr. David C. Classen, an associate professor of medicine at the University of Utah, put it, “The more you look for errors, the more you find.”³⁸²

“The Social Cost Of Adverse Medical Events, And What We Can Do About It,” National Center for Policy Analysis.

In 2006, medical mistakes contributed to up to 6.1 million injuries and 187,135 deaths in the United States.³⁸³ Lost lives and disabilities caused by medical error cost between \$393 billion and \$958 billion in 2006, equivalent to 18-45% of total US health-care spending in that year.³⁸⁴ “For every dollar that was spent in the health care system, about 18 to 45 cents of that dollar went to hurting someone,” explained co-author Pamela Villarreal in an April 7th briefing.³⁸⁵

“The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors,” Milliman Inc.

An analysis of insurance claims from 2001 through 2008 found approximately 564,000 injuries to patients admitted to U.S. hospitals and 1.8 million injuries to people using outpatient services.³⁸⁶ Preventable medical mistakes that harmed patients cost the United States \$17.1 billion in 2008.³⁸⁷ According to the researchers, “ten types of error account for more than two-thirds of the total cost of errors,” with the most common ones being pressure ulcers, postoperative infections and persistent back pain following back surgery.³⁸⁸ The single most expensive cause of harm – infection after surgery, with more

than 252,000 infections costing \$3.36 billion. The most common preventable event – pressure ulcers, with nearly 375,000 cases costing \$3.27 billion.³⁸⁹

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2010.

- “Of the nearly 1 million Medicare beneficiaries discharged from hospitals in October 2008, about ***1 in 7*** experienced an adverse event that met at least 1 of our criteria (13.5 percent).”³⁹⁰ “An estimated 1.5 percent of Medicare beneficiaries experienced an event that contributed to their deaths, which projects to 15,000 patients in a single month.”
- “Physician reviewers determined that ***44 percent of adverse and temporary harm events were clearly or likely preventable***. ... Preventable events were linked most commonly to medical errors, substandard care, and lack of patient monitoring and assessment.”³⁹¹ “Because many adverse events we identified were preventable, our study confirms the need and opportunity for hospitals to significantly reduce the incidence of events.”
- “Hospital care associated with adverse and temporary harm events cost Medicare an estimated \$324 million in October 2008. Sixteen percent of sample beneficiaries in the Medicare Inpatient Prospective Payment System who experienced events incurred additional Medicare costs as a result. The added costs equate to an estimated 3.5 percent of Medicare’s expenditure for inpatient care during October 2008. To give these figures an annual context, 3.5 percent of the \$137 billion Medicare inpatient expenditure for FY 2009 equates to ***\$4.4 billion*** spent on care associated with events. Two-thirds of Medicare costs associated with events were the result of entire additional hospital stays necessitated by harm from the events. Additionally, these Medicare cost estimates do not include additional costs required for follow-up care after the sample hospitalizations.”³⁹²

❖ **STATE-SPECIFIC ERROR TRENDS ARE SIMILAR.**

- **Connecticut.** A recent state Department of Public Health report³⁹³ on errors by acute care, chronic disease and mental hospitals plus non-hospital owned outpatient surgical facilities cited “431 reports of adverse events reported in 2016 and 181 events reported during the first six months of 2017.” Of those 431 adverse events reported, 43 percent were for pressure ulcers, 17 percent for falls resulting in death or serious injury and 14 percent for perforations during open, laparoscopic and/or endoscopic procedures. These three categories accounted for 74 percent of events reported and have been the top three reported errors year after year.³⁹⁴ The next most commonly reported event in 2016 and the first half of 2017 was sexual abuse or assault (24 reports), followed by 20 reports of “retained objects after surgery from 2016,” including “guide wire piece (4), foreign object (3), catheter tip (3), gauze (2), and single items (8).”
- **Indiana.** The state Health Department revealed 110 reported medical errors in 2017, with 105 of those events occurring at hospitals. Since 2006, the average number of

reported medical errors per year since has been 106. The most common errors for 2017 were: post-surgery retention of a foreign object (34 events); stage 3 or 4 pressure ulcers acquired after admission (28 events); surgery on the wrong body part (23 events); and fall-related death or serious disability or death (11 events). “These were the same top four (4) reported events in all but two (2) of the years of medical error reporting.”³⁹⁵

- **Iowa.** “Nearly one in five Iowans say they’ve had personal experience with medical errors, such as surgical mistakes, wrong diagnoses or incorrect medications, a new poll shows. In more than half of those cases, medical staff members did not inform the patients.” Among those who experienced medical errors, “59 percent said the mistakes happened in hospitals” and “29 percent said the mistakes happened in clinics...” In addition, “[s]ixty percent of those who experienced medical errors said the mistakes caused serious health consequences. Ninety percent believed the errors were preventable.”³⁹⁶
- **Massachusetts.** Acute care hospitals disclosed over 920 errors that harmed or threatened patients in 2017, including: 49 cases when the wrong site surgery or procedure was done on a patient; 52 instances when a medication error killed or seriously injured a patient; 294 cases of serious pressure ulcer; 308 instances of death or serious injury after a fall; 31 instances of unintended foreign object retention; 25 cases of death or serious injury from burn; and 11 instances of delivery-related newborn death or serious injury.³⁹⁷
- **Minnesota.** “In 2018, the total number of reported events was 384, the highest number of events in the fifteen years of reporting. ... This increase in total events was largely driven by a rise in pressure ulcers, retained foreign objects and the loss or damage of irreplaceable biological specimens. With respect to harm, there were 11 deaths and 118 serious injuries that resulted from the reported events. ... While the number of deaths is similar to most previous years, the number of serious injuries in 2018 increased. Over the life of the reporting system, falls, medication errors and neonatal events have been the most common causes of serious patient injury or death. The pattern was similar in 2018; five of the 11 deaths were associated with falls, three with the death of a neonate, two with medication errors and one as the result of a suicide.” Moreover, “[a]s in previous years, falls and pressure ulcers were the most commonly reported types of events, accounting for 58 percent of all events reported (223 events). The four event types that make up the surgical/invasive procedure category accounted for another 21 percent of events this year, with 82 events.”³⁹⁸
- **Pennsylvania.** Between January 1, 2018 and December 31, 2018, Pennsylvania acute care facilities reported 276,263 incidents, of which 8,086 were “Serious” (*i.e.*, “results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient”), with over 200 of those events resulting in or contributing to a patient’s death. “Error related to Procedure/Treatment/Test” was the most common category of incident report, accounting for 31 percent of all reports submitted.³⁹⁹

- **Washington.** In 2018, hospitals and other health care facilities reported a total of 687 adverse events. Among the errors cited: wrong site procedure (30 instances), wrong surgical procedure (12 instances), retained foreign object (57 instances), medication error (36 instances), fall resulting in death or serious injury (150 instances) and pressure ulcers (336 instances).⁴⁰⁰

“Temporal Trends in Rates of Patient Harm Resulting from Medical Care,” Harvard Medical School Associate Professor of Medicine and Pediatrics Christopher P. Landrigan, M.D., M.P.H., et al., 2010.

- “In a statewide study of 10 North Carolina hospitals, we found that *harm resulting from medical care was common*, with little evidence that the rate of harm had decreased substantially over a 6-year period ending in December 2007.... Since North Carolina has been a leader in efforts to improve safety, a lack of improvement in this state suggests that further improvement is also needed at the national level.⁴⁰¹
- “Our findings validate concern raised by patient-safety experts in the United States and Europe that harm resulting from medical care remains very common. Though disappointing, the absence of apparent improvement is not entirely surprising. Despite substantial resource allocation and efforts to draw attention to the patient-safety epidemic on the part of government agencies, health care regulators, and private organizations, the penetration of evidence-based safety practices has been quite modest. For example, only 1.5% of hospitals in the United States have implemented a comprehensive system of electronic medical records, and only 9.1% have even basic electronic record keeping in place; only 17% have computerized provider order entry. Physicians-in-training and nurses alike routinely work hours in excess of those proven to be safe. Compliance with even simple interventions such as hand washing is poor in many centers.”⁴⁰²

❖ DIAGNOSTIC ERRORS ARE THE MOST COMMON AND COSTLY ERRORS.

Red Signal Report: Claims Data Signals & Solutions to Reduce Risks and Improve Patient Safety, Coverys, 2019.

An analysis of more than 1,800 closed medical malpractice claims brought against primary care doctors from 2013 to 2018 revealed not only that diagnostic errors were the leading cause of liability claims (46 percent) and accounted for the highest proportion of payouts (68 percent) but also that 45 percent of injuries in diagnostic-related cases resulted in a patient’s death.⁴⁰³

“Reflections on Diagnosis and Diagnostic Errors: a Survey of Internal Medicine Resident and Attending Physicians,” Yale Medical School Physical Examination Director, Clinical Reasoning Director and Instructor Thilan Wijesekera, M.D., M.H.Sc., Associate Professor of Medicine Lisa Sanders, M.D., FACP, and Associate Professor of Medicine, Primary Care Residency Program Resident Research Director and General Internal Medicine Medical Education Fellowship Director Donna Windish, M.D., M.P.H., 2019.

A study analyzing responses from hundreds of residents and attending physicians at nine Connecticut internal medicine training programs – and published in the May 15, 2019 *Journal of General Internal Medicine* – revealed that “[a]lthough clinicians are often unsure of diagnoses, they tend to underestimate the rate of diagnostic errors and frequently fail to recognize how diagnostic testing affects patients....” More specifically, “despite the high rate of diagnostic uncertainty among clinician respondents, most believed that diagnostic errors were uncommon. The majority thought they occurred once a month or less frequently (inpatient, 54%; outpatient, 60%). This is in stark contrast with findings in [a 2015 National Academy of Medicine report], which indicated that diagnostic errors arise in 10% to 15% of patient encounters....”⁴⁰⁴

2019 Top 10 Patient Safety Concerns for Healthcare Organizations, ECRI Institute, 2019.

Diagnostic errors, together with improper management of test results in electronic health records (EHRs), ranks as the top patient safety concern for 2019. This was ECRI’s finding after examining patient safety data in conjunction with extensive expert input.⁴⁰⁵

“Diagnosis,” Society to Improve Diagnosis in Medicine, 2018.

“[I]t’s estimated that roughly 40,000-80,000 deaths in U.S. hospitals each year can be attributed to an inaccurate or delayed diagnosis. Every nine minutes, a person dies in U.S. hospitals due to wrong or delayed diagnosis.”⁴⁰⁶

“Learning From Patients’ Experiences Related To Diagnostic Errors Is Essential For Progress In Patient Safety,” Baylor College of Medicine Assistant Professor and Houston VA Medical Center for Innovations in Quality, Effectiveness and Safety Researcher Traber Davis Giardina, Ph.D., M.S.W., et al., 2018.

Baylor College of Medicine researchers analyzed 465 written patient- and family-reported error narratives submitted between January 2010 and February 2016 and “identified 184 unique patient narratives of diagnostic error. Problems related to patient-physician interactions emerged as major contributors” to errors in 75 percent of the accounts.⁴⁰⁷ Among the behaviors cited:⁴⁰⁸

- Physicians ignored or disregarded patients’ knowledge.

- Physicians disrespected patients by belittling, mocking and stereotyping.
- Physicians failed to communicate effectively or refused to speak with patients and family members.
- Physicians used fear to influence care decisions, misled patients or misinformed them.

Diagnostic Accuracy: Room for Improvement, Coverys, 2018.

Analysis of over 10,500 closed medical malpractice liability claims from 2013-2017 revealed the following.⁴⁰⁹

- Misdiagnoses are the largest root cause of all medical liability claims, accounting for one-third of all claims and 47 percent of indemnity payments.
- Surgical/procedural failures are the second largest root cause of claims, accounting for nearly a quarter of all claims and 18 percent of indemnity payments.
- 53% of misdiagnosis claims include risk management issues involving poor clinical decision-making.
- 54% of misdiagnosis claims are high severity cases, and 36% result in death.
- 36% of misdiagnosis claims stem from outpatient (office setting) locations.

2018 Medical Malpractice Payout Analysis, Diederich Healthcare, 2018.

An analysis of 2017 National Practitioner Data Bank (NPDB) data revealed that error in diagnosis was the most common type of allegation in paid claims (34 percent), followed by surgical errors (22 percent) and errors related to treatment (19 percent).⁴¹⁰

“Hospital transfers can leave diagnoses behind,” Minneapolis Star Tribune, July 28, 2018.

When analyzing data on patient transfers from one hospital to another, University of Minnesota doctors discovered discrepancies in lists of diagnoses in 85 percent of transfers. “Worse yet, they found that patients with inconsistent diagnostic records were more likely to die in hospital care.”⁴¹¹

Americans' Experiences with Medical Errors and Views on Patient Safety, NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute, 2017.

A 2017 nationwide survey investigating Americans' experiences with medical errors revealed the following:⁴¹²

- “While a range of errors are reported in the survey, the most commonly reported type of error is related to diagnosis. Fifty-nine percent of those with medical error experience report that the patient experienced a medical problem that was not diagnosed, was diagnosed incorrectly, or that a diagnosis was delayed. ...Forty-two percent say they received a diagnosis that didn't make sense. Forty-six percent say a mistake was made during a test, surgery, or treatment,” while 28 percent say they were administered the wrong amount of medication or incorrect medication.

Improving Diagnosis in Health Care, Institute of Medicine, 2015.

“The delivery of health care has proceeded for decades with a blind spot: Diagnostic errors – inaccurate or delayed diagnoses – persist throughout all settings of care and continue to harm an unacceptable number of patients. For example:

- A conservative estimate found that 5 percent of U.S. adults who seek outpatient care each year experience a diagnostic error.
- Postmortem examination research spanning decades has shown that diagnostic errors contribute to approximately 10 percent of patient deaths.
- Medical record reviews suggest that diagnostic errors account for 6 to 17 percent of hospital adverse events.
- Diagnostic errors are the leading type of paid medical malpractice claims, are almost twice as likely to have resulted in the patient's death compared to other claims, and represent the highest proportion of total payments.

In reviewing the evidence, the committee concluded that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences.”⁴¹³

“25-Year summary of US malpractice claims for diagnostic errors 1986-2010: an analysis from the National Practitioner Data Bank,” Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, M.D., Ph.D., et al., 2013.

Johns Hopkins researchers reviewed National Practitioner Data Bank data from the past 25 years and found that “diagnostic errors [*i.e.*, diagnoses that are missed, wrong or delayed] – not surgical mistakes or medication overdoses – accounted for the largest

fraction of claims, the most severe patient harm, and the highest total of penalty payouts.”⁴¹⁴ More specifically, between 1986 and 2010,

- Of the 350,706 paid claims, “diagnostic errors were the leading type (28.6 percent).”
- “The majority of diagnostic errors were missed diagnoses, rather than delayed or wrong ones.”
- “[M]ore diagnostic error claims were rooted in outpatient care than inpatient care, (68.8 percent vs. 31.2 percent) but inpatient diagnostic errors were more likely to be lethal (48.4 percent vs. 36.9 percent).”
- “Diagnostic errors resulted in death or disability almost twice as often as other error categories.”
- “[A]mong malpractice claims, the number of lethal diagnostic errors was roughly the same as the number that resulted in permanent, severe harm to patients. This suggests that the public health impact of these types of mistakes is probably much greater than previously believed because prior estimates are based on autopsy data, so they only count deaths and not disability....”
- Diagnostic errors “accounted for the highest proportion of total payments (35.2 percent).”
- “Diagnosis-related payments amounted to \$38.8 billion between 1986 and 2010....”
- “Per-claim payments were highest in cases of serious neurologic harm, including quadriplegia and brain damage resulting in the need for lifelong care. Those payments, the researchers found, were higher even than for errors resulting in death.”
- “While the new study looked only at a subset of claims – those that rose to the level of a malpractice payout – researchers estimate the number of patients suffering misdiagnosis-related, potentially preventable, significant permanent injury or death annually in the United States ranges from 80,000 to 160,000.”
- “The human toll of mistaken diagnoses is likely much greater” than this review showed because the data used “covers only cases with the most severe consequences of diagnostic error. There are many others that occur daily that result in costly patient inconvenience and suffering.... One estimate suggests that when patients see a doctor for a new problem, the average diagnostic error rate may be as high as 15 percent.”

As leader researcher Dr. David E. Newman-Toker explained, “This is more evidence that diagnostic errors could easily be the biggest patient safety and medical malpractice problem in the United States.... There’s a lot more harm associated with diagnostic errors than we imagined.”⁴¹⁵

“The frequency of diagnostic errors in outpatient care: estimations from three large observational studies involving US adult populations,” Michael E. DeBakey VA Medical Center’s Quality & Informatics Program Health Policy Chief and Baylor College of Medicine Associate Professor Hardeep Singh, M.D., M.P.H., et al., 2014.

After analyzing empirical data from several published studies that examined diagnosis and follow-up visits, Singh and his associates concluded that “[a]t least one in 20 adults is misdiagnosed in outpatient clinics in the US every year, amounting to 12 million people nationwide.”⁴¹⁶ As a result, misdiagnoses pose a “substantial patient safety risk,” with half of these errors being potentially harmful.⁴¹⁷

“Diagnostic errors in the intensive care unit: a systematic review of autopsy studies,” Bradford Winters et al., 2012.

- According to a 2012 study from the Johns Hopkins University School of Medicine, “as many as 40,500 critically ill patients in the United States may die annually when clinicians fail to diagnose hidden life-threatening conditions such as heart attack and stroke. The unexpectedly high frequency of deadly misdiagnosis in hospital intensive care units or ICUs was ‘surprising and alarming,’ said Dr. Bradford Winters, the lead author of the study.”⁴¹⁸
- Specifically, “one in four patients – 28 percent – had a missed diagnosis at the time of their death. In about 8 percent of patients, the misdiagnosis was serious enough to have caused or contributed to the patients’ deaths...” These ICU errors are “as much as 50 percent more common than that in general hospital patients.”

❖ ADDITIONAL CATEGORIES AND CAUSES OF UNSAFE CARE.

Childbirth.

“Maternal deaths and injuries: Top 10 takeaways from USA TODAY investigation of hospitals,” USA TODAY, March 11, 2019.

- “Thousands of mothers are needlessly dying or sustaining life-altering injuries because of medical mistakes and poor care.”
- “Hospitals know how to protect mothers. They just aren’t doing it. About half of maternal deaths and injuries could be prevented or reduced with better medical care. For years, experts have recommended that doctors, nurses and hospitals follow safety practices known to save lives. But USA TODAY found that, at some hospitals, less than 15% of women experiencing childbirth emergencies quickly received recommended treatments.”

- Hemorrhage and high blood pressure “are among the leading killers of new moms, but they also are among the most preventable with better medical care. As many as 90% of hemorrhage deaths and 60% of hypertension deaths could be prevented.”
- “Moms suffer complications far more often at some hospitals. ... About one of every eight hospitals – 120 in all – had rates double the norm.”⁴¹⁹

Maternal/Fetal Risks: Using Claims Analysis to Improve Outcomes, Coverys, 2019.

The insurer’s analysis of 472 obstetric-related closed claims across a five-year period (2013-2017) revealed the single largest cause of obstetrical claims was “alleged negligence during the management of labor – accounting for 40% of claims and 49% of indemnity paid.” Risks included failure to: “Recognize and act on nonreassuring fetal heart tracings”; “Monitor mother/fetus during administration of high-risk medications (e.g., oxytocin and magnesium sulfate)”; and “Recognize and act on obstetric emergencies.”⁴²⁰

“Clinical capital and the risk of maternal labor and delivery complications: Hospital scheduling, timing and cohort turnover effects,” Colorado State University Departments of Economics and Epidemiology Associate Professor Sammy Zahran et al., 2019.

Researchers analyzed Texas Dept. of State Health Services data on more than two million cases from 2005 to 2010 and found that the quantity of delivery complications are substantially higher in teaching hospitals. More specifically,

- “Mothers delivering their infants in teaching hospitals are 2.2 times more likely to experience a delivery complication than mothers birthing at non-teaching hospitals.”
- “The risk also increases by a multiplicative factor of 1.3 at teaching hospitals in July, when new residents join the staff rotation. By June, after a full year of training and integration, the risk of a delivery complication at these same hospitals is statistically indistinguishable from chance.”⁴²¹

Children.

“Principles of Pediatric Patient Safety: Reducing Harm Due to Medical Care,” American Academy of Pediatrics, 2019.

In February 2019, the medical association issued a policy statement outlining studies that reflect the extent to which children suffer avoidable medical errors.⁴²² Among the research cited:

- “Errors in prescribing, dispensing, and administering medications represent a substantial portion of the preventable medical errors in children despite electronic prescribing.”
- “A study of hospitalized, pediatric, nonnewborn patients in the United States revealed a medication error rate of 1.81 to 2.96 per 100 discharges. Teaching hospitals and settings where patients had more complex medical needs showed significantly higher error rates....”
- “Other studies, including one in which a trigger tool was used, have revealed myriad nonmedication harms, with total rates as high as 40 harms per 100 patients. Harms reported include accidental extubation, pressure ulcers, patient misidentification, delays in diagnosis, intravenous infiltrates, and other adverse events attributed to communication, training, and systems failures.”
- “Pediatric errors in emergency department (ED) settings may be attributable to multiple factors, including incorrect patient identification, lack of experience of many ED staff with pediatric patients versus with adults, and challenges with performing technical procedures in and calculating medication doses for children. Other sources of error include communication between prehospital and ED staff; among ED staff, particularly during change-of-shift sign off; between ED and inpatient staff; and between ED staff and family members.”

“U.N.C. Doctors Were Alarmed: ‘Would I Have My Children Have Surgery Here?’” *New York Times*, May 31, 2019.

There are “concerns about the quality and consistency of care provided by dozens of pediatric heart surgery programs across the country.... At least five pediatric heart surgery programs across the country were suspended or shut down in the last decade after questions were raised about their performance.”⁴²³

“Heartbroken,” *Tampa Bay Times*, November 28, 2018.

“*Times* reporters spent a year examining the All Children’s Heart Institute – a small, but important division of the larger hospital devoted to caring for children born with heart defects.” Among the findings:

- All Children’s surgeons made serious mistakes, and their procedures went wrong in unusual ways. They lost needles in at least two infants’ chests. Sutures burst. Infections mounted. Patches designed to cover holes in tiny hearts failed.
- In just a year and a half, at least 11 patients died after operations by the hospital’s two principal heart surgeons. The 2017 death rate was the highest any Florida pediatric heart program had seen in the last decade.

- Parents were kept in the dark about the institute’s troubles, including some that affected their children’s care. [One] family didn’t know [their child] caught pneumonia in the hospital until they read her autopsy report. The parents of another child didn’t learn a surgical needle was left inside their baby until after she was sent home.”⁴²⁴

“Adverse Events in Hospitalized Pediatric Patients,” Children’s National Medical Center Critical Care Specialist David C. Stockwell, M.D., et al., 2018.

- “Incidence of adverse events in hospitalized pediatric patients showed no decline from 2007 to 2012....”⁴²⁵
- Examination of 3,790 admissions revealed a total of 414 adverse events. “The most common were hospital-acquired infections (77 events), followed by intravenous line complications (60 events) and respiratory-related harms (53 events). Notably, a little over half of adverse events (n=210) were preventable....”
- A little over half of adverse events “contributed to or resulted in temporary harm to the patient and required intervention” and a little over a third were “contributed to or resulted in temporary harm to the patient and required initial or prolonged hospitalization,” while 10 percent were life-threatening and “three caused or contributed to a patient’s death.”

“Parent-Reported Errors and Adverse Events in Hospitalized Children,” Harvard Medical School and Boston Children’s Hospital Researcher Alisa Khan, M.D., M.P.H., et al., 2016.

- Roughly one in ten parents spotted safety incidents that their child’s physician did not.⁴²⁶
- 62 percent of the safety incidents parents reported were medical mistakes.
- 30 percent of those medical mistakes caused harm and were preventable.
- Children suffering medical errors appeared to have longer hospital stays.
- “Parents identified communication problems as a contributing factor in a number of errors, including instances when day and night staff didn’t note a medication change and when written information for one patient was documented in a different patient’s medical record.”

Clinics, Doctors' Offices, Surgery Centers.

“Lax Oversight Leaves Surgery Center Regulators And Patients In The Dark,” *USA TODAY Network, August 9, 2018.*

“A Kaiser Health News and USA Today Network investigation found that surgery centers operate under such an uneven mix of rules across U.S. states that fatalities or serious injuries can result in no warning to government officials, much less to potential patients. The gaps in oversight enable centers hit with federal regulators' toughest sanctions to keep operating, according to interviews, a review of hundreds of pages of court filings and government records obtained under open records laws. No rule stops a doctor exiled by a hospital for misconduct from opening a surgery center down the street.”⁴²⁷

“Analysis of Closed Claims Data in Ambulatory Surgical Centers,” Beth Israel Deaconess Medical Center Resident Joseph Foley, M.D., et al., 2017.

- “Between 2007 and 2014, a total of 944 anesthesiology claims and lawsuits were filed. Of that total, 290 (30.7%) arose from events in ASCs [Ambulatory Surgical Centers].”⁴²⁸
- “High-severity claims made up 19 percent of all ASC-related claims. About half of those high-severity claims involved patient deaths.”⁴²⁹
- “The most common allegation – comprising 26% of all claims – was intubation-related damage to the teeth, followed by improper performance of an anesthetic procedure. ‘Injection of an anesthetic agent into a peripheral nerve was one of the most common procedures leading to the formation of a claim,’ Dr. Foley said. This was followed by intubation-related adverse events, such as injuries to the vocal cords and esophageal tears. ‘Finally, there were spinals – injection into the sympathetic nerve – and miscellaneous procedures, which included incorrect placement of an IV.’”⁴³⁰
- “The next most common claim was for improper management of a patient under anesthesia, which comprised 20% of all ASC-related claims....”⁴³¹

“As surgery centers boom, patients are paying with their lives,” *Kaiser Health News/USA Today, March 2, 2018.*

- “An investigation by Kaiser Health News and the USA TODAY Network has discovered that more than 260 patients have died since 2013 after in-and-out procedures at surgery centers across the country. Dozens – some as young as 2 – have perished after routine operations, such as colonoscopies and tonsillectomies.”⁴³²

- “Reporters examined autopsy records, legal filings and more than 12,000 state and Medicare inspection records, and interviewed dozens of doctors, health policy experts and patients throughout the industry, in the most extensive examination of these records to date. The investigation revealed,” among other things:⁴³³
- “Some surgery centers are accused of overlooking high-risk health problems and treat patients who experts say should be operated on only in hospitals, if at all. At least 25 people with underlying medical conditions have left surgery centers and died within minutes or days. They include an Ohio woman with out-of-control blood pressure, a 49-year-old West Virginia man awaiting a heart transplant and several children with sleep apnea.”
- “Some surgery centers risk patient lives by skimping on training or lifesaving equipment. Others have sent patients home before they were fully recovered. On their drives home, shocked family members in Arkansas, Oklahoma and Georgia discovered their loved ones were not asleep but on the verge of death. Surgery centers have been criticized in cases where staff didn’t have the tools to open a difficult airway or skills to save a patient from bleeding to death.”
- “Kaiser Health News and the USA TODAY Network found more than a dozen cases where the absence of trained staff or emergency equipment appears to have put patients in peril.”
- “Doctors in surgery centers may excel at the procedures they perform most often. But the centers aren’t always prepared and sometimes struggle in a crisis, according to a review of Medicare records and more than 70 lawsuits.”

Office-Based Surgery Adverse Event Reporting 2010-2013, New York State Department of Health, 2014.

Between 2010 and 2013, there were 2,202 adverse events reported by just under 1,000 accredited “office based surgery” practices in NY state. 257 of those 2,202 events resulted in death, meaning that a patient died from close to 12 percent of the adverse events reported.⁴³⁴

Concurrent Surgeries.

“Association of Overlapping Surgery With Perioperative Outcomes,” Stanford University Medical School Assistant Professor of Anesthesiology, Perioperative and Pain Medicine and Health Services Research Eric Sun, M.D., Ph.D. et al., 2019.

As explained by *NPR’s Shots Blog*, “The practice of double-booking the lead surgeon’s time seemed to put [high-risk] patients” (*i.e.*, older patients, those with pre-existing medical conditions, and those undergoing coronary artery bypass

graft surgery) “at significantly higher risk of post-op complications, such as infections, pneumonia, heart attack or death.”⁴³⁵

“Concurrent surgeries come under new scrutiny,” *Boston Globe*, December 20, 2015.

- “A Globe survey of 47 hospitals nationwide found that it is common for surgeons to start a second operation before the first is complete, often after the surgeries were deliberately scheduled to overlap briefly. However, some surgeons have operations that run simultaneously for longer periods. And few hospitals call on doctors to explicitly tell patients when their operations are double-booked.”⁴³⁶
- Some “major hospitals either have no written concurrent surgery policy or declined to discuss the topic altogether. More than a dozen institutions, including Stanford Health Care, New York-Presbyterian Hospital, and the University of Pittsburgh Medical Center, refused to answer any questions.”
- “At Mass. General, the Globe found, a small group of medical staffers complained about at least 44 alleged problems involving concurrent surgeries in the last decade. They included cases where surgeons allegedly didn’t respond when an urgent need arose or didn’t show up, leaving the surgery to a resident or fellow; cases of patient complications, including the deaths of two elderly patients; cases where patients waited under anesthesia for the surgeon to arrive or return; and cases where operating room staff were confused about who would do the operation.”
- “Hospitals are fairly consistent on one thing: not requiring surgeons to explicitly tell patients when they will be caring for a second patient at the same time.”

Emergency Rooms.

The hospital location with the highest proportion of negligent adverse events (52.6 percent) is the emergency department,⁴³⁷ where people without health insurance often go for primary care.

“Deprived of Care: When ERs Break the Law,” *WebMD* and *Georgia Health News*, November 29, 2018.

“Though [the federal Emergency Medical Treatment and Labor Act, requiring that emergency departments to treat emergency patients regardless of ability to pay] EMTALA has been on the books for more than 30 years, hospitals are still violating it hundreds of times a year, sometimes with devastating results for patients.

“WebMD and Georgia Health News analyzed 10 years of EMTALA violations by hospitals around the United States from March 2008 to March 2018. The records, obtained under a Freedom of Information Act request, show cases where complaints were substantiated by investigators for the federal Centers for Medicare and Medicaid Services, meaning the hospital was found to be at fault. Our investigation found:

- More than 4,300 violations from 1,682 hospitals in total over 10 years.
- Violators represent about a third of the nation’s approximately 5,500 hospitals, according to statistics from the American Hospital Association.
- Failure to do a thorough medical screening exam was the most common violation committed by hospitals, accounting for more than 1,300 citations, nearly twice as many as the second most common violation: transferring patients inappropriately.
- In a deeper analysis of investigation reports from January 2016 to March 2018, at least 34 patients died during that period after emergency departments violated the law.
- A medical condition often cited in these violations was pregnancy. About 1 in 12 involved women who were pregnant or in labor. About 1 in 7 involved patients who were having a mental health crisis, including having suicidal thoughts.

“Yet experts say the raw numbers belie both the scope and severity of the problems they see. That’s because enforcement of the law depends on someone filing a complaint. Although anyone can file a complaint, it’s most often a doctor, nurse, or hospital administrator.

“[According to Howie Mell, MD, an emergency doctor in Chicago and a spokesman for the American College of Emergency Physicians, when you do see an EMTALA violation recorded in the system, it’s usually because something really serious happened. ‘They were either really egregious, or what you’re seeing is the tip of the iceberg’ for that hospital, Mell says.”⁴³⁸

“Do EPs change their clinical behaviour in the hallway or when a companion is present? A cross-sectional survey,” Brigham and Women’s Hospital Emergency Physician Hanni Stoklosa, M.D., M.P.H., et al, 2018.

- “Patients are more likely to be misdiagnosed or experience treatment delays when emergency rooms are so crowded that they receive care in a hallway,” according to a 2015 survey of emergency room physicians.⁴³⁹

- “Overall, nine in 10 doctors surveyed said they changed or shortened how they took patient medical histories when another person was present, and more than half of the physicians also altered how they did physical exams.”⁴⁴⁰

“Early death after discharge from emergency departments: analysis of national US insurance claims data,” Harvard Medical School Health Care Policy Assistant Professor and Brigham and Women’s Hospital Emergency Medicine Assistant Professor Ziad Obermeyer, M.D., et al., 2017.

- “Every year, a substantial number of Medicare beneficiaries die soon after discharge from emergency departments, despite no diagnosis of a life limiting illnesses recorded in their claims.”⁴⁴¹
- “In this national analysis, we found that over 10,000 Medicare beneficiaries each year died within seven days after being discharged from emergency departments, despite mean age of 69 and no obvious life limiting illnesses.”
- “For context, these deaths accounted for 1.7% of all non-hospice deaths in the Medicare fee for service population annually. Variability in mortality rates across hospitals was striking: hospitals with low patient volumes and lower admission rates had the highest rates of early death, and small increases in admission rates were linked to large decreases in risk – despite the fact that hospitals with low admission rates served emergency department populations with lower overall near term mortality.”

Home Health Agencies.

“Hospital discharge: It’s one of the most dangerous periods for patients,” Kaiser Health News, May 2, 2016.

- A Kaiser Health News analysis of federal inspection records showed that medication errors are frequently missed by home health agencies. More specifically, between January 2010 and July 2015, “inspectors identified 3,016 home health agencies – nearly a quarter of all those examined by Medicare – that had inadequately reviewed or tracked medications for new patients. In some cases, nurses failed to realize that patients were taking potentially dangerous combinations of drugs, risking abnormal heart rhythms, bleeding, kidney damage and seizures.”⁴⁴²
- In addition, “[o]ver the first half of this decade, 1,591 agencies – one in eight – had a defect inspectors considered so substantial that it warranted the agencies’ removal from the Medicare program unless the lapses were remedied.”

Hospice Care.

“No One is Coming:’ Investigation Reveals Hospices Abandon Patients at Death’s Door,” *TIME/Kaiser Health News*, October 25, 2017.

- The nation’s 4,000-plus hospice agencies “pledge to be on call around the clock to tend to a dying person’s physical, emotional and spiritual needs. It’s a thriving business that served about 1.4 million Medicare patients in the U.S. in 2015, including over a third of Americans who died that year, according to industry and government figures.

“Yet as the industry has grown, the hospice care people expect – and sign up for – sometimes disappears when they need it most. Families across the country, from Appalachia to Alaska, have called for help in times of crisis and been met with delays, no-shows and unanswered calls, a Kaiser Health News investigation published in cooperation with TIME shows.

“The investigation analyzed 20,000 government inspection records, revealing that missed visits and neglect are common for patients dying at home. Families or caregivers have filed over 3,200 complaints with state officials in the past five years. Those complaints led government inspectors to find problems in 759 hospices, with more than half cited for missing visits or other services they had promised to provide at the end of life.

“Only in rare cases were hospices punished for providing poor care, the investigation showed.”⁴⁴³

- There were “more than 1,000 citizen complaints that led state investigators across the country to uncover wrongdoing from January 2012 to February 2017, federal records show. But the complaints offer only a glimpse of a larger problem, said Dr. Joan Teno, a researcher at University of Washington who has studied hospice quality for 20 years. ‘These are people who got upset enough to complain.’”
- “Just how often are hospice patients left in the lurch? Inspection reports, performed by states and collected by CMS, don’t give a clear answer, in part because hospices are reviewed so infrequently. Unlike nursing homes, hospices don’t face inspection every year to maintain certification.”
- “Often, promising to do better is the only requirement hospices face, even when regulators uncover problems. ...CMS records show termination is rare. Through routine inspections as well as those prompted by complaints, CMS identified deficiencies in more than half of 4,453 hospices from Jan. 1, 2012 to Feb. 1, 2017. During that same time period, only 17 hospices were terminated, according to CMS.”

“Is that hospice safe? Infrequent inspections mean it may be impossible to know,” *Washington Post*, June 26, 2014.

- “The typical hospice in the United States undergoes a full government inspection about once every six years, according to federal figures, making it one of the least-scrutinized areas of U.S. health care – even though about half of older Americans receive hospice care at the ends of their lives. By contrast, nursing homes are inspected about once a year, and home health agencies every three years....”⁴⁴⁴
- “Even as the U.S. hospice industry has grown rapidly, caring for some of society’s most vulnerable, the companies that provide hospice services are rarely reviewed for competency.”
- “It is impossible to say precisely how many hospice companies might be cited for violations if there were more scrutiny, but a significant portion of them appear to be providing scant care, Medicare statistics and interviews show.”
- “Another fundamental problem: Hospices can boost profits by short-changing patients. Medicare pays hospice companies per patient, per day of care. For a ‘routine’ day of care, a hospice is paid about \$150, regardless of how many services it provides. That means that stinting on nurse visits, for example, could boost profit margins....”

“Terminal neglect? How some hospices treat dying patients,” *Washington Post*, May 3, 2014.

- “[A]bout one in six U.S. hospice agencies, serving more than 50,000 of the terminally ill, did not provide either form of crisis care to any of their patients in 2012, according to an analysis of millions of Medicare billing records. The absence of such care suggests that some hospice outfits are stinting on nursing attention, according to hospice experts. Inspection and complaint records, meanwhile, depict the anguish of patients who have been left without care.”⁴⁴⁵

Hospital “Off-Hours.”

“Clinical capital and the risk of maternal labor and delivery complications: Hospital scheduling, timing and cohort turnover effects,” *Colorado State University Departments of Economics and Epidemiology Associate Professor Sammy Zahran et al.*, 2019.

“[T]he quantity of delivery complications in hospitals are substantially higher during nights, weekends and holidays, and in teaching hospitals.” This was the finding after researchers analyzed Texas Dept. of State Health Services data on more than two million cases from 2005 to 2010. More specifically,

- “The odds of a mother experiencing a delivery complication are 21.3 percent higher during the night shift, and that the odds of a delivery complication increase 1.8 percent with every hour worked within a shift.”
- “A mother delivering an infant on a weekend is 8.6 percent more likely to encounter a complication than a mother delivering on a weekday.”
- “Births occurring on holidays are particularly susceptible to labor or delivery complications, with holiday births being 29.0 percent more likely to have a complication.”⁴⁴⁶

“Trends in Survival After In-Hospital Cardiac Arrest During Nights and Weekends,” Temple University Assistant Professor of Medicine and Geisinger Health System Critical Care Physician Uchenna R. Ofoma, M.D., M.S., et al., 2018.

“Hospital patients who have a cardiac arrest may be more likely to die if it happens in the middle of the night or on a weekend than if it occurs on a weekday,”⁴⁴⁷ according to researchers examining data on over 151,000 adults who experienced cardiac arrest at 470 U.S. hospitals from 2000 through 2014.

“Weekend Effect for Percutaneous Coronary Intervention Admissions: A 10-Year U.S. Experience,” Mount Sinai Hospital Resident Byomesh Tripathi, M.D., et al., 2017.

Review of 2004-2013 data revealed that patients admitted to the hospital for a heart attack on the weekend were twice more likely to die than those hospitalized for a heart attack on a weekday.⁴⁴⁸

“Association between day and month of delivery and maternal-fetal mortality: weekend effect and july phenomenon in current obstetric practice,” Baylor College of Medicine Obstetrics and Gynecology Professor Steven L. Clark, M.D., et al., 2017.

- Researchers analyzed outcomes from over 45 million pregnancies in the United States between 2004 and 2014 and found that weekend delivery was “associated with differential maternal and neonatal morbidity, including increased ratios of perineal lacerations, maternal transfusions, neonatal intensive care admissions, immediate neonatal ventilation requirements, neonatal seizures and antibiotic use.”⁴⁴⁹
- As the lead author explained, “Any system that shows this sort of variation in the most important of all system outcomes is, by definition, badly broken. Our data suggest that a part of the overall dismal U.S. obstetric performance may be related to this systems issue, that is, there may be a ‘spill over’ effect that is demonstrably

worse on weekends but is also present on weekdays to a lesser extent. Our data does not allow us to go any further than this in terms of specifying what the problem is. However, we believe it is likely due to the fact that rarely is care of the pregnant inpatient the primary concern of the treating physician – it is almost always a distraction from office, surgery or personal activities.”⁴⁵⁰

“Incidence of ‘never events’ among weekend admissions versus weekday admissions to US hospitals: national analysis,” University of Southern California Medical School Neurosurgery Clinical Instructor Frank J. Attenello, M.D., et al., 2015.

Researchers analyzed data from more than 350 million U.S. hospital admissions from 2002 to 2010 and found the following:⁴⁵¹

- “Even though most admissions - 81 percent - were on weekdays, preventable complications were more common on weekends. Hospital-acquired conditions occurred in 5.7 percent of weekend admissions, compared to 3.7 percent in people admitted on weekdays.”
- As the study’s lead author told *Reuters*, ““This increased hospital-acquired condition rate is significant because we found presence of at least one hospital-acquired condition to be associated with an 83 percent likelihood of increased healthcare cost and a 38 percent increase in the likelihood of a prolonged hospital stay....”

“The ‘Weekend Effect’ in Pediatric Surgery – Increased Mortality for Children Undergoing Urgent Surgery During the Weekend,” Johns Hopkins Surgical Resident Seth D. Goldstein, M.D., et al., 2014.

According to the study, published in the *Journal of Pediatric Surgery*, “even after controlling for sex, age, race, the type of surgery and other factors, patients having a procedure on the weekend were 40 percent more likely to sustain an accidental puncture or cut, 14 percent more likely to receive a transfusion, and 63 percent more likely to die.”⁴⁵²

Hospital Transfers.

“Hospital transfers can leave diagnoses behind,” *Minneapolis Star Tribune*, July 28, 2018.

- In a 2017 study, Stanford University researchers “found that patients who move from one hospital to another experience longer stays, more medical mistakes and greater odds of dying in care.”⁴⁵³

Intensive Care Units (ICUs).

“Prospective evaluation of medication-related clinical decision support over-rides in the intensive care unit,” Brigham and Women’s Hospital Outcomes Research and Pharmacy Informatics Fellow Adrian Wong, PharmD, M.P.H., BCPS, BCCCP, et al., 2018.

- Clinical decision support (CDS) alerts in electronic medical records serve to “remind clinicians about everything from a patient’s drug allergies, to possible drug interactions, to dosing guidelines, to lab testing guidance. Clinicians can either follow the alerts’ recommendations or override or ignore them.”⁴⁵⁴
- Researchers studying medication-related CDS alert over-rides among adults admitted to Brigham and Women’s ICUs between July 2016 and April 2017 found that nearly 20 percent of over-rides were inappropriate. Moreover, “inappropriate over-rides were six times as likely to be associated with potential and definite ADEs [adverse drug events], compared with appropriate over-rides.”⁴⁵⁵

Lower-Volume Hospitals.

“Safety in Numbers,” *U.S. News & World Report*, June 21, 2017.

- “The analysis of four years of data from hospitals across the country indicates that 26 percent of deaths – more than 1 out of every 4 – that occur following surgery for the most severe heart defects could be prevented by having the operation performed at hospitals where surgical teams do the greatest numbers of procedures.”⁴⁵⁶
- “In 4,000 of the most complex procedures performed, U.S. News found that 104 of 395 deaths could have been prevented if the patients – most of whom in such surgeries are children – had their operations in high-volume centers that treat 250 or more patients needing congenital heart surgery in a year. Nine hospitals studied, the data show, performed an average of just two or fewer of the riskiest and most challenging procedures per year.”
- “Data were drawn from 61 hospitals that allowed their information to be publicly released. And experts say the actual number of preventable deaths may be far higher, because many hospitals – especially the poorest performers – are unwilling to release their data publicly, which would allow it to be analyzed....”
- “Little has changed, however, since the first research linked volume to outcomes in the 1970s. Smaller surgical programs continue to perform procedures best left to surgeons at more experienced institutions, even when there’s a high-volume hospital nearby.”

- “The reasons for the health care industry’s reluctance to act include the same forces that shape so much else in medicine: prestige and money. Hospitals mindful of their reputation and bottom line encourage doctors to keep patients in-house, rather than referring them to rivals with the experience and resources to care for them. Surgeons also oppose efforts to limit the scope of their practice.”

Neonatal Intensive Care Unit (NICU).

“Use of Temporary Names for Newborns and Associated Risks,” Montefiore Health System Patient Safety Officer and Hospital Medicine Assistant Professor Jason Adelman, M.D., M.S., et al., 2015.

Researchers found that hospitals’ practice of assigning temporary, non-distinct first names such as Babyboy or Babygirl to newborns resulted in a high incidence of wrong-patient errors in the Neonatal Intensive Care Unit (NICU). According to the study, which was “designed to measure wrong-patient electronic orders, there are other types of misidentification errors in NICUs that may result from the use of nondistinct first names, such as reading imaging tests or pathology specimens for the wrong patient or administering blood products to the wrong patient. One particularly concerning wrong-patient error unique to NICUs and hospital nurseries is feeding a mother’s expressed breast milk to the wrong infant.”⁴⁵⁷

Non-Teaching Hospitals.

“Association Between Teaching Status and Mortality in US Hospitals,” Harvard T.H. Chan School of Public Health Instructor and Beth Israel Deaconess Medical Center Emergency Medicine Physician Laura G. Burke, M.D., M.P.H., et al., 2017.

Researchers analyzed 21 million hospitalizations of Medicare beneficiaries from 2012 through 2014 and found that “[o]lder adults treated at major teaching facilities are less likely to die in the weeks and months following their discharge than patients admitted to ‘non-teaching’ or community hospitals....” As the study’s lead author told *Healthday*, “[F]or every 84 patients treated at a major teaching hospital that otherwise would have gone to a non-teaching hospital, one fewer patient dies,” or put another way, “If death rates at non-teaching hospitals were similar to major teaching facilities, there would be roughly 58,000 fewer deaths per year among these patients....”⁴⁵⁸

Nursing Homes/Long-Term Care Facilities/Skilled Nursing Units.

“CMS Could Use Medicare Data To Identify Instances Of Potential Abuse Or Neglect,” Office of Inspector General, U.S. Department of Health and Human Services, 2019.

“We identified 34,664 Medicare claims for our audit period that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries. We estimated 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our population associated with incidents of potential abuse or neglect, 2,574 were allegedly perpetrated by a healthcare worker, 3,330 were related to incidents that occurred in a medical facility, and 9,294 were related to incidents that were not reported to law enforcement.”⁴⁵⁹

***Families' and Residents' Right to Know: Uncovering Poor Care in America's Nursing Homes*, U.S. Senators Bob Casey (D-Pa.) and Pat Toomey (R-Pa.) 2019.**

“Investigative reporting, however, continues to identify facilities that fall short of the care standards required of every one of our nation’s nursing homes. In such facilities, some residents have experienced outright neglect, such as going without proper nutrition or languishing in filthy conditions. Some older adults and people with disabilities have even experienced physical abuse, sexual assault and premature death.

“Many documented cases of abuse and neglect occur in facilities affiliated with the federal Special Focus Facility (SFF) program. The SFF program is designed to increase oversight of facilities that persistently underperform in required inspections conducted by state survey agencies....

Since 2005, more than 900 facilities have been placed on the SFF *candidate* list.”⁴⁶⁰

“Association Between High Discharge Rates of Vulnerable Patients and Skilled Nursing Facility Copayments,” University of Pennsylvania General Internal Medicine Assistant Professor Paula Chatterjee, M.D., M.P.H. et al., 2019.

As reported by *Reuters*,⁴⁶¹

- “Skilled nursing facilities in the U.S. often discharge Medicare patients before daily co-payments kick in,” suggesting that “some patients may be sent home for financial reasons before they’re medically ready to leave.”

- “Overall, a total of 220,037 patients were discharged on day 20, more than the 131,558 sent home on day 19 and the 121,339 released on day 21. Compared to patients discharged on days 19 or 21, those sent home on day 21 were more likely to suffer from multiple chronic medical conditions, live in poor neighborhoods, and be racial or ethnic minorities, the study found.”

“Avoidable Sepsis Infections Send Thousands Of Seniors To Gruesome Deaths,” *Kaiser Health News/Chicago Tribune*, September 5, 2018.

- “Year after year, nursing homes around the country have failed to prevent bedsores and other infections that can lead to sepsis.... [A] federal report has found that care related to sepsis was the most common reason given for transfers of nursing home residents to hospitals and noted that such cases ended in death ‘much more often’ than hospitalizations for other conditions.”⁴⁶²
- “Poor infection control ranks among the most common citations in nursing homes. Since 2015, inspectors have cited 72 percent of homes nationally for not having or following an infection-control program.”
- “A special analysis conducted for KHN by Definitive Healthcare, a private health care data firm, also suggests that the toll – human and financial – from such cases is huge. Examining data related to nursing home residents who were transferred to hospitals and later died, the firm found that 25,000 a year suffered from sepsis, among other conditions.”
- Inspectors have “cited 37 percent of the nation’s nursing homes” for “risks of pressure sores or failure to treat them properly....”
- Kaiser Health News “identified more than 8,000 suits filed nationwide from January 2010 to March [2018] that allege injuries from failing to prevent or treat pressure sores and other serious infections.”

“Medicare Takes Aim At Boomerang Hospitalizations Of Nursing Home Patients,” *Kaiser Health News*, June 13, 2018.

- “[M]any homes, with their sometimes-skeletal medical staffing, often fail to handle post-hospital complications – or create new problems by not heeding or receiving accurate hospital and physician instructions.”⁴⁶³
- “Patients, caught in the middle, may suffer. One in 5 Medicare patients sent from the hospital to a nursing home boomerangs back within 30 days, often for potentially preventable conditions such as dehydration, infections and medication errors, federal records show. Such rehospitalizations occur 27 percent more frequently than for the Medicare population at large.”

- “Out of the nation’s 15,630 nursing homes, one-fifth send 25 percent or more of their patients back to the hospital, according to a Kaiser Health News analysis of data on Medicare’s Nursing Home Compare website.”
- “Nursing homes have been unintentionally rewarded by decades of colliding government payment policies, which gave both hospitals and nursing homes financial incentives for the transfers. That has left the most vulnerable patients often ping-ponging between institutions, wreaking havoc with patients’ care.”

A Few States Fell Short in Timely Investigation of the Most Serious Nursing Home Complaints: 2011-2015, Office of Inspector General, U.S. Department of Health and Human Services, 2017.

OIG analyzed 2011 to 2015 data on the rate of nursing home complaints, their severity and how well states responded to those complaints and reported the following:⁴⁶⁴

- “Overall, States received one-third more nursing home complaints in 2015 than in 2011. While the number of nursing home residents decreased slightly between 2011 and 2015, the number of nursing home complaints States received increased 33 percent, from 47,279 to 62,790. Over this 5-year period, the number of complaints that States received per 1,000 nursing home residents increased from 32.7 to 44.9 complaints per year.”
- “Each year, half of all nursing home complaints required prompt onsite investigation.”
- “Each year, States prioritized about 7 percent of complaints as immediate jeopardy, a level that requires a State to conduct an onsite investigation within 2 working days. Although the proportion of total complaints remained about 7 percent, the number of immediate jeopardy complaints almost doubled during this time, from 2,844 to 5,341. In addition, States prioritized about 50 percent of complaints each year as high priority....”
- “In 2015, States prioritized 59 percent of complaints as either immediate jeopardy or high priority, compared to 55 percent in 2011.”
- “Among the most serious complaints, the most common allegations related to quality of care or treatment. Between 2011 and 2015, for complaints prioritized as immediate jeopardy or high priority, States categorized an average of 42 percent of the allegations as relating to quality of care or treatment. In 2015, allegations regarding quality of care or treatment were the most common (41 percent), followed by allegations regarding resident neglect (12 percent) and resident rights (8 percent).”

“Poor Patient Care at Many Nursing Homes Despite Stricter Oversight,” *New York Times*, July 5, 2017.

- “While special focus status is one of the federal government’s strictest forms of oversight, nursing homes that were forced to undergo such scrutiny often slide back into providing dangerous care, according to an analysis of federal health inspection data. Of 528 nursing homes that graduated from special focus before 2014 and are still operating, slightly more than half – 52 percent – have since harmed patients or put patients in serious jeopardy within the past three years.”⁴⁶⁵
- “These nursing homes are in 46 states. Some gave patients the wrong medications, failed to protect them from violent or bullying residents and staff members, or neglected to tell families or physicians about injuries, inspection records show. Years after regulators conferred clean bills of health, levels of registered nurses tend to remain lower than at other facilities.”
- “Yet, despite recurrences of patient harm, nursing homes are rarely denied Medicare and Medicaid reimbursement. Consequences can be dire for patients....Regulators rarely return homes to the watch list, instead issuing fines for subsequent lapses. Some homes continue operating despite multiple penalties.”
- “...Special focus facility status is reserved for the poorest-performing facilities out of more than 15,000 skilled nursing homes. ...More than 900 facilities have been placed on the watch list since 2005. But the number of nursing homes under special focus at any given time has dropped by nearly half since 2012, because of federal budget cuts. This year, the \$2.6 million budget allows only 88 nursing homes to receive the designation, though regulators identified 435 as warranting scrutiny. Especially troubling is that more than a third of operating nursing facilities that graduated from the watch list before 2014 still hold the lowest possible Medicare rating for health and safety: one star of five, the analysis found.”

“How hospitals, nursing homes keep lethal ‘superbug’ outbreaks secret,” *Reuters*, December 22, 2016.

“Long-term care facilities – nursing homes, rehab centers and the like – are particularly vulnerable to outbreaks. A *Reuters* analysis of death certificates found that from 2003 to 2014, annual superbug-related deaths at long-term care facilities increased 62 percent, from about 1,400 to almost 2,300. Patients in these facilities are ideal superbug targets – the chronically ill, the very old, and anyone else with a compromised immune system.”⁴⁶⁶

Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2014.

- During August 2011, an “estimated 22 percent of Medicare beneficiaries experienced adverse events during their SNF stays.”⁴⁶⁷ More specifically, approximately 21,777 patients were harmed and 1,538 died due to substandard skilled nursing care in a single month.⁴⁶⁸
- “Physician reviewers determined that 59 percent of these adverse events and temporary harm events were clearly or likely preventable. They attributed much of the preventable harm to substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.”⁴⁶⁹
- “Over half of the residents who experienced harm returned to a hospital for treatment, with an estimated cost to Medicare of \$208 million in August 2011. This equates to \$2.8 billion spent on hospital treatment for harm caused in SNFs in FY 2011.”

Plastic Surgery.

“Women seeking discount plastic surgery paid with their lives at clinics opened by felons,” USA TODAY, April 23, 2019.

- “One man pleaded guilty to bank fraud. One was convicted of grand theft in a real estate scam. Two others admitted to elaborate Medicare schemes that siphoned millions from taxpayers. In Florida, one of the nation’s top destinations for plastic surgery, a felony conviction can bar someone from operating a massage parlor or a pawn shop. But not from running a cosmetic surgery clinic.”
- “Nearly a dozen miles from the iconic beaches of South Florida, the four convicted felons ran facilities that became assembly lines for patients from across the country seeking the latest body sculpting procedures at discount prices. And at those businesses, at least 13 women have died after surgeries. Nearly a dozen others were hospitalized with critical injuries, including punctured internal organs.”⁴⁷⁰

Plastic Surgery Closed Claims Study, Doctors Company, 2016.

A recent Doctors’ Company analysis of 1,438 claims against plastic surgeons closed from January 2007 through June 2015 found that “technical performance” (e.g., “performing a procedure on an incorrect body site, misidentifying an anatomical structure, and using poor technique”) contributed to patient harm in 42 percent of claims. Among the most common injuries suffered: emotional trauma (35 percent), scarring (23 percent), cosmetic injury (14 percent), infection (12 percent), burns (6 percent), ongoing pain (6 percent), tissue necrosis (4 percent), nerve damage (4 percent) and death (3 percent).⁴⁷¹

Rehabilitation Hospitals.

Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries, Office of Inspector General, U.S. Department of Health and Human Services, 2016.

After reviewing a nationally representative sample of medical records of Medicare beneficiaries discharged from rehab hospitals in March 2012, OIG found the following:⁴⁷²

- “An estimated 29 percent of Medicare beneficiaries experienced adverse or temporary harm events during their rehab hospital stays, resulting in temporary harm; prolonged stays or transfers to other hospitals; permanent harm; life-sustaining intervention; or death. This harm rate is in line with what we found in hospitals (27 percent) and in [skilled nursing facilities] (33 percent).”
- “Physician reviewers determined that 46 percent of these adverse and temporary harm events were clearly or likely preventable.”
- “Nearly one-quarter of the patients who experienced adverse or temporary harm events were transferred to an acute-care hospital for treatment, with an estimated cost to Medicare of at least \$7.7 million in one month, or at least \$92 million in one year, assuming a constant rate of hospitalization throughout the year.”

Resident Hand-Off.

“Increased Mortality Associated with Resident Handoff in a Multi-Center Cohort,” University of Colorado Pulmonary and Critical Care Fellow Joshua Denson, M.D. et al., 2016.

- Researchers reviewed thousands of internal medicine patient discharges from ten Veterans Administration hospitals between 2008 and 2014 and found that the “risk of patient death significantly increases when medical residents leave their monthly clinical rotations and turn their patients’ care over to other residents....”⁴⁷³
- More specifically, for patients experiencing a transition in care from an intern (a first-year medical resident), resident or both an intern and resident there was a 64-95 percent increase in in-hospital mortality, a 76-82 percent increase in 30-day mortality and a 72-84 percent increase in 90-day mortality.
- “Researchers also noted that the highest mortality risk occurred among handoffs to only an intern, which suggests that level of training is a contributing factor.”

Stress/Burnout.

“Acute mental stress and surgical performance,” Columbia University Data Science Institute Master’s Candidate Peter Dupont Grantcharov et al., 2019.

The study, published in the *British Journal of Surgery*, “reveals that during stressful moments in the operating room, surgeons make up to 66 percent more mistakes on patients. Using a technology that captured the electrical activity of a surgeon’s heart, researchers found that during intervals of short-term stress, which can be triggered by a negative thought or a loud noise in the operating room, surgeons are much more prone to make mistakes that can cause bleeding, torn tissue, or burns.”⁴⁷⁴

“Physician burnout: contributors, consequences and solutions,” Mayo Foundation for Medical Education and Research Directors Colin P. West, M.D., Ph.D., Liselotte N. Dyrbye, M.D., MHPE, and Tait D. Shanafelt, M.D., 2018.

The Mayo Clinic-Rochester “longitudinal Internal Medicine Resident Well-Being (IMWELL) Study found that higher levels of burnout were associated with increased odds of reporting a major medical error in the subsequent 3 months. Self-perceived major medical errors were also associated with worsening burnout, depressive symptoms and decrease in quality of life, suggesting a bidirectional relationship between medical errors and distress. . . . Other studies have found that increased emotional exhaustion levels of physicians working in intensive care units are associated with higher standardized patient mortality ratios,” plus “[i]ncreased physician depersonalization levels have been shown to relate to longer recovery times for hospitalized patients postdischarge.”⁴⁷⁵

“Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors,” Stanford University Medical School Pediatric Critical Care Instructor Daniel Tawfik, M.D., M.S., et al., 2018.

A Stanford University Medical School survey of physicians in active practice across the United States revealed the following:⁴⁷⁶

- 55 percent of doctors reported symptoms of burnout, with over 10 percent also reporting that they’d made at least one major medical error during the three months prior to being surveyed.
- 78 percent of doctors reporting errors had symptoms of burnout.
- Physicians with burnout were more than twice as likely to make a medical error.

- “[H]ealth care facilities where doctor burnout was seen as a common problem saw their medical error risk rate triple, even if the overall workplace environment was otherwise thought to be very safe.”
- The most common medical errors made were errors in medical judgment, errors in diagnosis and technical mistakes during procedures.
- More than five percent of physician errors led to permanent health problems, while 4.5 percent resulted in a patient’s death.
- “An unsafe work environment was found to triple to quadruple the risk for committing a medical error.”
- “Physician burnout is at least equally responsible for medical errors as unsafe medical workplace conditions, if not more so...”
- “The key finding of this study...is that both individual physician burnout and work-unit safety grades are strongly associated with medical errors.”

“Pediatric Resident Burnout and Attitudes Toward Patients,” Harvard Medical School Department of Medicine Physician Tamara Elizabeth Baer, M.D., M.P.H., et al., 2017.

- “A large number of pediatricians in training may already be experiencing burnout, a recent U.S. study suggests, and those who do are more likely to make errors or take shortcuts during treatment.”⁴⁷⁷
- “Burned out residents were seven times more likely to make treatment or medication errors that were not due to inexperience or lack of knowledge, compared with residents who were not burned out.”
- “Residents reporting burnout were 3.5 times more likely not to fully discuss treatment options or answer a patient’s questions and four times more likely to discharge a patient to make the service more manageable.”

Work Shift Timing.

“Association of Primary Care Clinic Appointment Time With Clinician Ordering and Patient Completion of Breast and Colorectal Cancer Screening,” Perelman School of Medicine Assistant Professor and Penn Medicine Center for Innovation Director of Operations Shivan J. Mehta, M.D., M.B.A., et al., 2019.

Researchers examined two years of data on patient visits from 33 primary care practice sites at the University of Pennsylvania Health System and found greater risks to patient health if doctors examined them toward the end of the morning

and afternoon shifts. More specifically, “[D]octors ordered fewer breast and colon cancer screenings for patients later in the day, compared to first thing in the morning. All the patients were due for screening, but ordering rates were highest for patients with appointments around 8 a.m. By the end of the afternoon, the rates were 10 percent to 15 percent lower. The probable reasons? Running late and decision fatigue.”⁴⁷⁸

❖ HOSPITALS PROFIT BY PROVIDING UNSAFE MEDICAL CARE.

“Association of the Hospital Readmissions Reduction Program Implementation With Readmission and Mortality Outcomes in Heart Failure,” Brigham and Women’s Hospital and Vascular Center Cardiovascular Research Fellow Ankur Gupta, M.D., Ph.D., et al., 2017.

- “Federal policymakers five years ago introduced the Hospital Readmission Reduction Program to spur hospitals to reduce Medicare readmission rates by penalizing them if they didn’t. A new analysis led by researchers at UCLA and Harvard University, however, finds that the program may be so focused on keeping some patients out of the hospital that related death rates are increasing.”
- “In a study of 115,245 fee-for-service Medicare beneficiaries at 416 hospitals, implementation of the reduction program was indeed linked to a decrease in readmissions at 30 days after discharge and at one year after discharge among people hospitalized for heart failure. But it was also linked to an increase in mortality rates among these groups of patients.”
- “‘To avoid the penalties, hospitals now have incentives to keep patients out of hospitals longer, possibly even if previously some of these patients would have been readmitted earlier for clinical reasons,’ said first author Dr. Ankur Gupta, cardiovascular research fellow at the Brigham and Women’s Hospital, Harvard Medical School. ‘Therefore, this policy of reducing readmissions is aimed at reducing utilization for hospitals rather than having a direct focus on improving quality of patient care and outcomes.’”⁴⁷⁹

“Medicare Payment Policy Creates Incentives For Long-Term Care Hospitals To Time Discharges For Maximum Reimbursement,” UCLA School of Public Health Health Policy and Management Department Chair and Professor Jack Needleman, Ph.D., FAAN, et al., 2015.

Long-term-care hospitals, which specialize in treating people with serious conditions who require prolonged care,⁴⁸⁰ “discharge a disproportionately large share of Medicare patients during a window when they stand to make the most money from reimbursements under the federal program,”⁴⁸¹ not because of patients’ needs or their best interests. Based on this money-making discharge approach, “Medicare had spent \$164 million in

excess reimbursements on the ventilator patients over the five-year period,” for example.⁴⁸²

“Hospital Discharges Rise at Lucrative Times,” *Wall Street Journal*, February 17, 2015.

- After analyzing Medicare claims paid from 2008 to 2013, the *WSJ* found that “long-term hospitals discharged 25% of patients during the three days after crossing thresholds for higher, lump-sum payments. That is five times as many patients as were released the three days before the thresholds.”⁴⁸³
- “Long-term-hospital executives sometimes pursued that goal for financial reasons rather than medical ones, say doctors, nurses and former long-term-hospital employees interviewed by the Journal.”⁴⁸⁴
- “More than 400 long-term, acute-care hospitals in the U.S. received about \$30 billion in Medicare payments from 2008 through 2013,” the *WSJ* reported.⁴⁸⁵
- “‘The pattern of discharging patients at the most lucrative juncture is ‘troubling and disturbing,’ says Tom Finucane, a doctor and professor at Johns Hopkins University School of Medicine, after learning of the Journal’s findings. ‘The health-care system should serve the patients and try to improve their health, and any step away from that is a corruption.’ Dr. Finucane and other medical experts say longer-than-necessary hospital stays increase risks for medical errors, infection and unnecessary care. Discharges that come too early can mean patients don’t get care they need.”⁴⁸⁶

“More than 450 hospitals pay over \$250 million in cardiac-device investigation,” *Modern Healthcare*, October 30, 2015.

- “More than 450 hospitals have settled with the government for more than \$250 million as part of a yearslong, nationwide investigation into the suspected overuse of implantable cardiac devices.”
- “The hospital systems involved include many of the country’s largest, such as Adventist, Ascension Health, Banner Health, Catholic Health Initiatives, Community Health Systems, HCA, Tenet Healthcare Corp. and Universal Health Services among others.”
- “At 42, HCA had the most hospitals involved in settlements and is paying the highest portion of the settlement, \$15.8 million, followed by Ascension Health with 32 settling for \$14.9 million and then Community Health Systems with 31 settling for \$13 million.”⁴⁸⁷

“The Association between Patient Safety Indicators and Medical Malpractice Risk: Evidence from Texas,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Northwestern University Department of Economics Ph.D. Candidate Zenon Zabinski, 2013.

- After studying Texas data on medical malpractice claims closed between 1988 and 2010,⁴⁸⁸ researchers found that “higher rates of adverse patient safety events predict higher rates of paid med mal risk claims. This suggests that med mal suits – at least the suits that lead to paid claims – are not random, and that hospitals can reduce their med mal risk by improving patient safety.” The authors conclude:

If hospitals can reduce adverse events at reasonable cost – as they apparently can, since some do so – why don’t they? Mello and Studdert (2007) find that hospitals are largely insulated from the financial costs associated from patient injuries, including those due to negligence. Krupka, Sandberg, and Weeks (2012) report that hospitals earn substantially higher revenue when surgical patients suffer complications than when they do not. O’Connor (2012) reports that only about 1% of hospitals have installed inexpensive sponge-tracking systems, which could reduce PSI 5 (Foreign Body Left during Procedure) rates to nearly zero. Writ large, the financial incentives for increasing patient safety, including those provided by med mal liability, are weak.

“Relationship Between Occurrence of Surgical Complications and Hospital Finances,” Harvard School of Public Health and Harvard Medical School Professor Atul Gawande, M.D., M.P.H., et al, 2013.

- “When patients suffer from complications on the operating table, hospitals reap huge profits, according to a new study to be published Wednesday in The Journal of the American Medical Association.”
- ““We’ve known for a while that we’re paying for quantity instead of quality, but the magnitude of the numbers behind what that meant have never been articulated,” Dr. Atul Gawande, one of the study’s authors, said in a phone interview. “What we found is, they’re eye-popping.””
- “Perverse financial incentives offered by private insurers and Medicare actually pad hospitals’ profits when surgeries go awry, according to the study.”
- “Hospitals earned 330 percent higher profit margins on surgeries with one or more complications when they were paid for by private insurers, according to the study. Surgeries with complications covered by Medicare earned 190 percent higher profit margins. That translates to approximately \$30,500 more per faulty surgery.”
- “The data are a gut-punch to the hospital industry at a time when health care stakeholders universally insist on reforms that pay for high-quality care, rather than quantity. It also

underscores the financial risks faced by providers that might be otherwise interested in payment reform but worry it could lead to instability or job losses if they end up losing funds and resources.”

- “‘The more effective their quality control department is, the more they lose,’ [Gawande] said. ‘We’re talking about massive amounts of losses if they improve quality.’”
- “‘The study indicates that some movement toward bundled payments – paying hospital systems fixed rates for different types of care, regardless of whether there’s a complication – has helped reverse the incentive to leave quality issues unaddressed. But most hospitals have yet to transition to such a system.’”⁴⁸⁹

❖ **THE SITUATION IS FAR WORSE BECAUSE MAJOR ERRORS GO UNREPORTED AND PATIENT SAFETY INFORMATION IS KEPT SECRET.**

**“Assessing the Quality of Public Reporting of US Physician Performance,”
University of Michigan School of Public Health Ph.D. Candidate Jun Li et al., 2019.**

There is an egregious lack of information regarding the safety records of individual doctors providing care to Medicare enrollees. Researchers came to this conclusion after looking at the scarce amount of data on 1 million U.S. doctors made available online by the U.S. Centers for Medicare and Medicaid Services.⁴⁹⁰ Among the study’s more troubling discoveries:

- Three quarters of clinicians have no information about their quality of care.
- 99 percent of those in the online system have no data tied to their individual job performance, “making it hard for patients to know who might be a better or worse choice among several physicians at one clinic.”
- “Doctors who did share individual level outcomes tended to have very high quality scores, suggesting that physicians may only opt into the voluntary reporting system when they know the results will make them look good....”
- “Clinicians also aren’t required to report data on outcomes for every patient, and they may choose only to submit information for cases that turned out well....”

“Maternal deaths and injuries: Top 10 takeaways from USA TODAY investigation of hospitals,” *USA TODAY*, March 11, 2019.

- “Hospitals often won’t say whether they follow key safety practices. Many maternity hospitals refused to answer basic questions about whether or not they are following specific safety protocols.... [W]hen USA TODAY repeatedly contacted 75 hospitals in 13 states, half would not disclose whether they are doing [basic safety] things.”

- “Safety data about maternity care is kept secret. Even though pregnancy and childbirth is the No. 2 reason for hospitalization in this country, the federal government doesn’t require hospitals to tell the public how often mothers die or suffer from childbirth complications... USA TODAY’s investigation for the first time published rates of severe childbirth complications at hundreds of hospitals. It’s a number that many hospitals and experts use privately – but don’t think should be shared publicly.”
- “Many states fail to track and study moms’ deaths. USA TODAY further revealed that state maternal death review committees across the country often avoid scrutinizing medical care that occurred in the days and hours before mothers’ deaths – instead focusing on women’s lifestyle choices or larger societal problems, like obesity, smoking and seatbelt use. Some states didn’t study mothers’ deaths at all.”⁴⁹¹

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2019.

- Hospitals infrequently report information to the National Practitioner Data Bank (NPDB) and use a tactics like the “corporate shield” to avoid reporting. “One study found that more than two-thirds of the hospitals examined reported no adverse events to the NPDB over a 5-year span. Another estimated that 75% of ‘potentially reportable actions’ and 60% of ‘unquestionably reportable actions’ went unreported.”⁴⁹²
- “Providers’ use of the so-called ‘corporate shield’ impairs the NPDB’s completeness too. The shield is employed when ‘the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB.’ Although the extent to which this tactic reduces the number of payments that are reportable to the NPDB is not known, some authors believe that one-half of otherwise reportable adverse events are deflected by this means.”
- “The University of Michigan Health System avowedly uses the corporate shield, and its settlements are generally in the institution’s name. ... [H]ence under this approach ‘reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare. However, full claims histories are maintained and reported for each involved caregiver, as required.’... Even though it rarely reports medical malpractice payments, it still actively reports adverse actions on a provider’s privileges or credentials to the NPDB.”

“Culture of Secrecy: How hospitals hide medical malpractice,” WEWS-TV 5, November 13, 2015.

- “An exclusive WEWS-TV investigation reveals the culture of secrecy surrounding medical malpractice. Investigators found hospitals carefully track medical mistakes but often keep detailed information about errors hidden from patients and the public.”⁴⁹³
- ““People who are injured as a result of medical malpractice are almost never told that has happened by their doctors or by hospitals where it’s happened,” said Maxwell Mehlman, the Director of the Law-Medicine Center at Case Western Reserve University.”
- The news investigation also discovered “how difficult it can be for patients to find out the truth about medical mistakes.”

“Enhanced Hospital Safety Score Helps Patients Track U.S. Hospitals’ Consistency in Preventing Harm,” Leapfrog Group, 2015.

“[P]erformance on safety outcomes – including preventing errors, accidents and infections – has not significantly improved,”⁴⁹⁴ with 40 percent of the 2,523 hospitals analyzed receiving a C, D or F grade.

2014 National Healthcare Quality and Disparities Report, Agency for Healthcare Research and Quality, 2014.

“On average, less than half of respondents within hospitals (44 percent) reported at least one [medical error] in their hospital over the past 12 months. It is likely that this represents underreporting of events,”⁴⁹⁵ which “means potential patient safety problems may not be recognized or identified and therefore may not be addressed.”

“Medical Harm: Patient Perceptions and Follow-up Actions,” Johns Hopkins University School of Medicine Professor of Surgery Marty Makary, M.D., M.P.H., et al., 2014.

According to the study, published in the *Journal of Patient Safety*, it’s rare for medical providers to voluntarily disclose errors to patients. Among the key findings:⁴⁹⁶

- “It was common for health care providers to withhold information about medical mistakes. Only 9 percent of patients said the medical facility voluntarily disclosed the harm.”
- “When officials did disclose harm it was often because they were forced to. Nine percent of respondents said the harm was only acknowledged under pressure.”
- “More than 30 percent reported paying bills related to the harm. The average cost: \$14,024.”

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm and Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

- According to a January 2012 study, “Hospital employees recognize and report only one out of seven errors, accidents and other events that harm Medicare patients while they are hospitalized.” This massive error “underreporting” problem at hospitals is because hospitals employees do not seem to know what patient harm is and if they do, they think it is someone else’s job to report it. Specifically, “[T]he problem is that hospital employees do not recognize ‘what constitutes patient harm’ or do not realize that particular events harmed patients and should be reported.... In some cases ... employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or ‘suspected that the events were isolated incidents unlikely to recur.’”⁴⁹⁷
- A July 2012 follow-up study found that “[a]lthough half of States operated adverse event reporting systems in 2008, hospitals reported few events to State systems. For all but one event that was not reported to State systems as required, the hospitals did not identify the events within internal incident reporting systems. This indicates that low reporting to State systems is more likely to result from hospital failure to identify events than from hospitals’ neglecting to report known events.”⁴⁹⁸
- Moreover, “[m]any of the events not reported to State systems as required involved serious harm to hospitalized Medicare beneficiaries. Six of the thirty-two events contributed to patient death, including cases involving lack of patient monitoring and missed diagnoses.... Other unreported events required the use of life-sustaining interventions, indicating that hospital staff were clearly alerted to a problem but still did not report the events.”⁴⁹⁹
- “Further, the less serious, temporary harm events that hospitals did not report included many events that can become serious if not ameliorated, such as excessive bleeding and intravenous volume overload. The treatment required to stop the progression of these events also implies that in each case, hospital staff were likely aware of the patient’s condition but did not perceive the condition as an event.”

“Year after report, patients still face risks,” Albany Times Union, 2010.

- A September 2010 *Hearst* newspapers investigation revealed that most states fail to report medical errors.⁵⁰⁰ According to the study, “Twenty-three states don’t have a medical-error detection program. Even those with mandatory programs miss a majority of the harm.”

- “Outside of New York and Pennsylvania, which have robust error reporting systems, a Hearst sampling showed other states with mandatory programs didn’t account for between 97 percent and 75 percent of harmful events — based on a conservative definition of harm.”

State-specific error reporting problems.

- **California.** “Eighty-seven hospitals – more than 20% of the 418 hospitals covered under a law that took effect in 2007 – have made no reports of medical errors, according to the California Department of Public Health.”⁵⁰¹
- **Nevada.** After examining 425,000 billing records in 2008 and 2009, the *Las Vegas Sun* “identified 3,689 cases of preventable harm that could be categorized as sentinel events, meaning Nevada law requires them to be reported to the state.”⁵⁰² According to the *Sun*, “During those same two years, all Nevada hospitals reported just 402 sentinel events.” “In its investigation, the Sun found that at the 13 acute-care hospitals in the Las Vegas Valley in 2008-09, there were: 710 surgical accidents; 2,010 cases where patients were infected with lethal bacteria; 969 cases of injuries such as bloodstream infections involving central-line catheters, advanced-stage pressure sores and postoperative falls.”
- **North Carolina.** “Most medical centers continue to depend on voluntary reporting to track institutional safety, despite repeated studies showing the inadequacy of such reporting.”⁵⁰³
- **Texas.** According to a 2009 investigative series by Hearst newspapers,⁵⁰⁴ after Texas enacted its cap on non-economic damages, “the number of complaints against Texas doctors to the Medical Board rose from 2,942 to 6,000 in one year. More than half of those complaints were about the quality of medical care.”⁵⁰⁵ Yet, “Texas has fumbled attempts to establish a medical error reporting system, often leaving patients to discover errors the hard way — when a mistake costs them their livelihood or the life of a loved one.” “In 2003, Texas hospitals were asked to report just nine broadly defined error categories. The Texas data kept from 2003 to 2007 kept hospital names secret. Only error totals were made available to the public.” The data on the Texas Department of State Health Services’ Web site is minimal and suspiciously low and “[f]amilies of patients found the general nature of the reporting infuriating.” What’s more, in 2003, “the Texas lawmakers established the fledgling Office of Patient Protection, designed to respond to complaints from the public not handled by the Medical Board.” But, “it never got the chance to work. The Legislature eliminated the agency in 2005 and, without resistance from the hospital lobby, eliminated the error reporting system in 2007.”
- **Washington.** The Hearst investigation found that, thousands are “harmed each year by medical care in Washington hospitals, some fatally and some suffering serious disabilities” and that even “[t]hrough Washington is one of 27 states that require hospitals and other facilities to report serious medical errors, just a fraction [of] the errors that likely happen here are reported.”⁵⁰⁶ “[T]here are likely at least 2,200 reportable incidents a year in Washington.” In 2009, facilities reported only 198 to the Washington health

department. “Washington’s medical error reporting program isn’t able to enforce the reporting law because it’s underfunded and lacks enforcement powers – and because the rules laying out which incidents must be reported make it easy for hospitals to rule that an error isn’t a ‘reportable error.’” “Nearly 7,000 patients spent 29,000 days at Yakima Regional last year; it is one of the largest facilities in the state that hasn’t filed any adverse event reports since the law went into effect in June 2006.” “Washington’s 162 walk-in surgery centers were added to the list of facilities required to report this year. In the first two quarters of 2010 only four of them have reported a total of five adverse events. Experts say that number is also incredibly low based on the volume of work being done in these facilities, which do more than 340,000 surgical procedures each year.”

❖ **MOST PATIENTS WORRY ABOUT MEDICAL ERRORS.**

Wolters Kluwer Health Survey, 2012.

- “Nearly three-quarters [73 percent] of patients say they are concerned about the potential for medical errors, according to a poll that sheds light on public perceptions of patient safety.”⁵⁰⁷
- “Three in 10 patients said they had experience with a medical error, either personally or through a close friend or family member.”
- “Twenty-one percent reported having been misdiagnosed by a physician....”

❖ **PATIENT SAFETY IS SUFFERING BECAUSE SO FEW INJURED PATIENTS SUE.**

“The Empirical Effects of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

“One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence. Studies of medical error consistently find that the vast majority of patients injured by medical error do not file a claim ... [H]ospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error.”⁵⁰⁸

Empirical Studies, National Center for State Courts, 2011.

- From 2000 to 2009, med mal filings fell by 18 percent in the general jurisdiction courts of 7 states reporting.⁵⁰⁹ In 5 of those states, filings fell by between 18 and 42 percent. Similarly, an April 2011 National Center for State Courts report, concluded that

“[c]ontrary to the claims of some tort reform advocates, medical malpractice caseloads have been decreasing over time.”⁵¹⁰

- Moreover, according to that April 2011 report, “despite the widespread prevalence of medical negligence,”⁵¹¹ in 2008 medical malpractice case filings “represented well under 2 percent of all incoming civil cases, and less than 8 percent of incoming tort cases” in the general jurisdiction courts of 12 states reporting.

***The Medical Malpractice Myth*, University of Pennsylvania Law School Professor Tom Baker, 2005.**

- “[T]here are far more cases of medical malpractice than medical malpractice litigation. Professor Danzon reported that there were 10 incidents of medical malpractice for every one malpractice claim in the United States. The Harvard group found a seven-to-one ratio in New York and Colorado and a five-to-one ratio in Utah. Because hospital record reviews miss so much medical malpractice, the real multiple is much higher.”
- “[T]he Harvard team looked at about 30,000 hospital records in New York and found conclusive evidence of a serious injury from medical malpractice in the records of 280 patients. How many of those 280 patients brought a claim? Eight. That is less than 3 percent.”
- “In Utah and Colorado, the team looked at about 15,000 hospital records and found conclusive evidence of a serious injury from medical malpractice in the records of 161 patients. How many of those 161 patients brought a claim? Four. That is also less than 3 percent.”⁵¹²

❖ LITIGATION, SETTLEMENTS AND INSURANCE PLAY CRITICAL SAFETY ROLES WHILE “TORT REFORM” LAWS HARM PATIENT SAFETY.

“The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,” Northwestern University Law School and Kellogg School of Management Professor Bernard Black and Bates White Competition and Antitrust Consultant Zenon Zabinski, Ph.D., 2019.

- “We examine whether caps on non-economic damages in medical malpractice cases affect in-hospital patient safety. We use Patient Safety Indicators (PSIs) – measures of adverse events – as proxies for safety. In difference-in-differences (DiD) analyses of five states that adopt caps during 2003-2005, we find that patient safety gradually worsens after cap adoption, relative to control states.”
- “We find a broad increase in adverse patient safety events following damage cap adoption, across both most individual PSIs and across composite measures that combine

related PSIs, both for individual states and pooled across states. In Texas, for example, PSI rates are generally stable or declining, relative to control states prior to reform. After reform, most PSI rates rise: 18 of the 21 measures have positive DiD coefficients; nine of these increases are statistically significant, while none of the three declines are statistically significant. This is consistent with hospitals reducing investments in patient safety. Across states and PSIs, we find a mean increase of about 15% in adverse events after reform.”

- “We find evidence that state adoption of caps on non-econ damages in medical malpractice lawsuits predicts higher rates of preventable adverse patient safety events in hospitals. To the best of our knowledge, our study is the first, either for medical malpractice or indeed, in any area of personal injury liability, to find strong evidence consistent with classic tort law deterrence theory: Liability for harm induces greater care and relaxing liability leads to less care. The drop in care quality occurs gradually over a number of years following adoption of damage caps.”
- “[O]ur results lend additional support for the conclusion that standards of care affect the behavior of healthcare provider. Higher standards can lead to higher healthcare quality; reduced liability pressure can lead to lower quality. ...Our results suggest that one should be cautious about relaxing tort liability without providing a substitute source of incentives.”⁵¹³

“How Liability Insurers Protect Patients and Improve Safety,” University of Pennsylvania Law School Professor Tom Baker and University of Texas at Austin Law School Professor Charles Silver, 2019.

- “[M]edical liability insurers exist, and therefore do everything that they do, only because injured patients have the right to legal recourse. Moreover, we know what we know about the landscape of adverse medical events largely because of medical malpractice claims. This is obviously the case for the many important studies that use insurance company closed claim files as the data source. However, people often forget that the most important, large-scale, hospital-based studies of adverse medical events had their origins in efforts by the medical profession to prove there was a better way to address patient injuries than tort litigation. While the studies failed to achieve that goal, they did achieve something important: documenting that serious adverse medical events are a major public health problem.”⁵¹⁴
- “[I]nsurers protect patients by providing compensation that helps insurers deal with the consequences of medical mistakes.... [I]t would be a mistake to view policy limits only as caps on injured patients’ recoveries because the existence of insurance coverage is what enables patients to obtain compensation. Insurers are the bankers for the tort system. Without them, the liability system as we know it could not function.”⁵¹⁵

“Clues to Better Health Care From Old Malpractice Lawsuits,” *Wall Street Journal*, May 9, 2016.

- “Doctors are learning valuable new lessons from past malpractice cases about mistakes that could put their patients at risk and expose them to lawsuits.”⁵¹⁶
- “Malpractice insurers and medical specialty groups are mining thousands of closed claims from suits that have been tried, dismissed or settled over the past few years. Their goal is to identify common reasons that doctors are sued and the underlying issues that threaten patient safety. They are sharing those insights with doctors and hospitals, which in turn are using them to develop new safety protocols and prevention strategies.”⁵¹⁷

***Lifesavers*, Center for Justice & Democracy, 2016.**

Numerous other medical practices have been made safer only after the families of sick and injured patients filed lawsuits against those responsible. In addition to anesthesia procedures, these include catheter placements, drug prescriptions, hospital staffing levels, infection control, nursing home care and trauma care.⁵¹⁸ As a result of such lawsuits, the lives of countless other patients have been saved.

“Uncovering the Silent Victims of the American Medical Liability System,” Emory University Associate Law Professor Joanna Shepherd, 2014.

- “Damage caps and other tort reforms that artificially reduce plaintiffs’ damage awards also reduce contingent fee attorneys’ expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept.... Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers.”⁵¹⁹
- “Empirical evidence suggests that the lack of victim compensation has, in turn, reduced the liability system’s deterrent effect by blunting incentives for the medical community to improve care; most studies find that malpractice liability does not influence physician behavior.”

“A Dose of Reality for Medical Malpractice Reform,” UCLA Law Professor Joanna C. Schwartz, 2012.

After conducting in-depth interviews and a nationwide survey of those responsible for risk management, claims management and quality improvement in hospitals around the country, Acting UCLA Law Professor Joanna C. Schwartz found that malpractice lawsuits enhance patient safety.⁵²⁰ As Schwartz explained in an August 2012 study,

“malpractice lawsuits are playing an unexpected role in patient safety efforts: as a source of relevant information about medical error. The vast majority of interviewees and survey participants report that their hospitals review legal claims, the information developed during the course of discovery, and closed claims for patient safety lessons.” Moreover, “litigation data has proven useful to hospital patient safety efforts. Lawsuits reveal allegations of medical negligence and other patient safety issues about which hospital were previously unaware; depositions and discovery materials surface previously unknown details of adverse events; analyses of claim trends reveal problem procedures and departments; and closed claims files serve as rich teaching tools.”

“The Empirical Effects Of Tort Reform,” Cornell University Law School Professor Theodore Eisenberg, 2012.

- “Evidence suggests that greater savings to hospitals and insurers can be achieved not at the expense of patient victims. ... Caps that reduce premiums by brute force likely discourage more painstaking but socially desirable efforts to improve safety.”⁵²¹
- “One possible factor contributing to the continued high rate of errors is that doctors do not expect to bear the full cost of harms caused by their negligence...[H]ospitals do not bear the full costs of the harms caused in them even though hospitals directly and indirectly influence patients’ risk of medical error (Mello et al. (2007)).”

CBO’s Analysis of the Effects of Proposals to Limit Costs Related to Medical Malpractice (“Tort Reform”), Congressional Budget Office, 2009.

The Congressional Budget Office (CBO), in an October 2009 analysis (in the form of a 7-page letter to Senator Orin Hatch), said, “The [medical malpractice] system has twin objectives: deterring negligent behavior on the part of providers and compensating claimants for their losses....”⁵²² CBO wrote that “imposing limits on [the right to sue for damages] might be expected to have a negative impact on health outcomes.” Of the three studies that address the issue of mortality that it examined, CBO noted that one study found tort system restrictions would lead to a .2 percent increase in the nation’s overall death rate. If true, that would be an additional 4,874 Americans killed every year by medical malpractice, or 48,740 Americans over the 10-year period CBO examines.⁵²³ Moreover, based on these same numbers, another 400,000 or more patients could be injured during the 10 years that CBO examined (given that one in 10 injured patients die⁵²⁴).

“The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” George J. Annas, J.D., M.P.H., 2006.

“In the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.... Anesthesiologists were motivated by litigation to improve patient safety. As

a result, this profession implemented 25-years-ago a program to make anesthesia safer for patients and as a result, the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.”⁵²⁵

❖ **“FEAR OF LITIGATION” IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS.**

Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, Office of Inspector General, U.S. Department of Health and Human Services, 2012.

A January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm.⁵²⁶ According to the HHS Inspector General, “[T]he problem is that hospital employees do not recognize ‘what constitutes patient harm’ or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or ‘suspected that the events were isolated incidents unlikely to recur.’”⁵²⁷

“Choosing Your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients,” University of Washington Internal-Medicine Physician Thomas Gallagher et al., 2006.

According to a 2006 study published in the *Archives of Internal Medicine*, comparisons of how Canadian and U.S. doctors disclose mistakes point to a “culture of medicine,”⁵²⁸ not lawyers, for their behavior. In Canada, there are no juries, non-economic awards are severely capped and “if patients lose their lawsuits, they have to pay the doctors’ legal bills,” “yet doctors are just as reluctant to fess up to mistakes.”⁵²⁹ Moreover, “doctors’ thoughts on how likely they were to be sued didn’t affect their decisions to disclose errors.” The authors believed “the main culprit is a ‘culture of medicine,’ which starts in medical school and instills a ‘culture of perfectionism’ that doesn’t train doctors to talk about mistakes.”

PART 6: SPECIAL PROBLEMS FOR VETS AND MILITARY FAMILIES

“The Department of Veterans Affairs’ (VA) Veterans Health Administration (VHA) operates one of the largest health-care systems in the nation, serving almost 9 million veterans annually in recent years.”⁵³⁰

Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care, U.S Government Accountability Office, 2019.

After examining how allegations of VA employee misconduct are investigated and resolved, GAO learned the following:

- “Some veterans seeking care at the Veterans Health Administration have been seen by providers who should have been disqualified from working for the massive veterans health care system,” GAO discovered. More specifically, the government watchdog “found that VHA has hired ineligible medical staff because it missed disqualifying information in a national database, like when a provider has been disciplined by a licensing board, or because hiring staff didn’t know providers with valid licenses were ineligible if they surrendered a license or got one revoked in another state. In one case, VHA hired a nurse whose license was revoked for patient neglect, the report noted, although the nurse has since resigned.”⁵³¹
- In addition, “GAO found that some facility officials were not aware of VHA employment policies. Specifically, GAO found that officials in at least five facilities who were involved in verifying providers’ credentials and hiring them were unaware of the policy regarding hiring a provider whose license has been revoked or surrendered for professional misconduct or incompetence, or for providing substandard care. As a result, these five VHA facilities hired or retained some providers who were ineligible.”⁵³²

“VA finishes lab-test review, finds 30 serious errors,” Arkansas Democrat Gazette, June 2, 2019; “3 deaths found in investigation of impaired pathologist,” Associated Press, September 24, 2018.

- A yearlong review of 33,902 pathology results from a single doctor – who had twice worked while drunk and was ultimately fired – revealed 3,029 errors, including 30 missed diagnoses posing serious health risks to patients.⁵³³
- The data reflected “an error rate of 8.9% compared with a pathology practice average of 0.7%”; in other words, “an error rate more than 12 times the average, figures show.”⁵³⁴

- In 2018, VA investigators undertook an initial review of 14,000 of the pathologist’s 33,000 cases and uncovered 1,119 cases with medical errors. Eleven of those errors had resulted in serious harm, including three deaths.⁵³⁵

Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability, U.S. Government Accountability Office, 2018.

“Our review of [the VA’s Office of Accountability Review] Legacy Referral Tracking List identified 70 out of 1,245 closed cases involving officials where misconduct was either substantiated, or partially substantiated, but no disciplinary action was recommended. One case involved three allegations of poor dental care provided to patients by three different senior officials. One physician cut underneath a patient’s tongue with the bur of a hand-piece drill (substantiated), another administered medication the patient was allergic to (partially substantiated), and the final senior official extracted the wrong tooth (substantiated). We did not find any evidence in the PAID system that these senior officials received disciplinary action. Further, OAR did not provide documentation to show that any disciplinary action had been proposed or taken. The physician that cut underneath a patient’s tongue received performance pay totaling \$15,000 approximately 6 days after the investigation had concluded that misconduct was substantiated. As of March 2018, two of these senior officials received performance pay, and appear to still be employed at VA.”⁵³⁶

Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Office of Inspector General, Department of Veterans Affairs, 2018.

OIG review of the Memphis VA Medical Center found a multitude of avoidable medical errors from October 1, 2015 through September 30, 2017, among them:⁵³⁷

- “Sixteen surgical inpatients with serious treatable conditions died while receiving care at the Facility. In each of these cases, Facility review processes had determined that high-risk patients had known pre-existing, complex, and comorbid health conditions that had not been optimized prior to being selected and/or cleared for surgery. Facility leaders identified a serious breakdown in communication/consultation with all providers involved in the patients’ overall care....”
- “Two patients developed central venous catheter related bloodstream infections, and 19 patients developed postoperative sepsis. Facility leaders stated this was directly attributable to a deficient number of acute care nursing staff, inefficient nursing staff training, and a lack of infection control/prevention protocols and follow up.”
- “Nine patients developed pressure ulcers while being hospitalized at the Facility. Nursing leaders initially attributed this to a deficient level of nurse training and staffing in acute care.”

- “In addition, six patients sustained a perioperative hemorrhage or hematoma, two patients developed an acute injury post-operatively that required dialysis, five patients developed postoperative respiratory failure, 12 patients developed pulmonary embolism or deep vein thrombosis, and one patient had unrecognized abdominopelvic accidental puncture/laceration. All 26 patients had comorbid and complex health conditions prior to being cleared for surgery; and, again, Facility leadership attributed inefficient provider communication/consultation processes, lack of rigorous surgical case review/selection, and lack of surgical case decision protocols to these patient complications and poor outcomes.”

“Secret data: Most VA nursing homes have more residents with bed sores, pain, than private facilities,” *Boston Globe/USA TODAY*, June 25, 2018.

- “An analysis of internal documents shows residents at more than two-thirds of Department of Veterans Affairs nursing homes last year were more likely to have serious bedsores, as well as suffer serious pain, than their counterparts in private nursing homes across the country.”⁵³⁸
- “The analysis suggests large numbers of veterans suffered potential neglect or medication mismanagement and provides a fuller picture of the state of care in the 133 VA nursing homes that serve 46,000 sick and infirm military veterans each year.”
- “More than 100 VA nursing homes scored worse than private nursing homes on a majority of key quality indicators, which include rates of infection and decline in daily living skills, according to the analysis of data withheld by the VA from public view but obtained by USA TODAY and The Boston Globe.”

“Secret VA nursing-home ratings hid poor quality care from public,” *Boston Globe/USA Today*, June 17, 2018.

VA nursing homes serve 46,000 veterans annually in 46 states, D.C. and Puerto Rico, operating with little public scrutiny of the substandard health care they provide patients. As discovered through a joint *Boston Globe/USA TODAY* investigation:⁵³⁹

- The VA “has tracked detailed quality statistics on its nursing homes for years but has kept them from public view, depriving veterans of potentially crucial health care information. Nearly half of VA nursing homes nationwide – 60 – received the agency’s lowest ranking of one out of five stars as of Dec. 31, 2017, according to documents obtained by USA Today and The Boston Globe.”
- “The worst-performing VA nursing homes in the ratings were scattered across 32 states, including Pennsylvania, which had five one-star facilities, as well as Texas and California, which had four each. The VA facility in Bedford and another in Brockton were the only one-star nursing homes out of six in New England.”

- “The VA quality tracking found that its nursing home residents were five times more likely to report being in pain than private nursing home residents” and six times more likely to have a “catheter left in their bladder, which can lead to urinary or blood infections and other complications.”

Critical Deficiencies at the Washington DC VA Medical Center, Office of Inspector General, Department of Veterans Affairs, 2018.

“Although the OIG did not identify patients who suffered death or other adverse clinical outcomes as a result of the identified problems, veterans were put at risk because important supplies and instruments were not consistently available in patient care areas.”⁵⁴⁰ In addition, the OIG found:

- “More than 300 patient safety events involved a reported problem with supplies, instruments, or equipment from January 1, 2014, through September 6, 2016, with more than 100 of these events not reported to the VHA National Center for Patient Safety as required by VHA policy; and
- The Patient Safety Manager failed to accurately and effectively track and trend patient safety events, resulting in the Medical Center missing opportunities to conduct Aggregated Reviews of supply, instrument, or equipment issues to identify and correct problems.”

“Investigative Findings Related to the VA Medical Center Manchester,” U.S. Office of Special Counsel, January 25, 2018.

Four whistleblowers disclosed that 100 out of approximately 170 patients treated in the VAMC Manchester Spinal Cord Unit “developed serious spinal cord disease as a result of clinical neglect at the VA”; that the former Chief of the Spinal Cord Unit “improperly copied and pasted patient chart notes for over 10 years”; and that the operating room “has repeatedly been infested with flies.”⁵⁴¹

“Illegal VA policy allows hiring since 2002 of medical workers with revoked licenses,” USA TODAY, December 21, 2017.

- “The Department of Veterans Affairs has allowed its hospitals across the country to hire health care providers with revoked medical licenses for at least 15 years in violation of federal law, a USA TODAY investigation found.”⁵⁴²
- Among the doctors allowed to treat veterans despite having a revoked license: a neurosurgeon “who had revealed in his application that he had numerous malpractice claims and settlements and Wyoming had revoked his license after a patient death. He still had a license in Montana.”⁵⁴³

Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, U.S. General Accountability Office, 2017.

Five VA medical centers (VAMCs) failed to responsibly execute required reviews of nearly 150 providers from October 2013 through March 2017 after concerns were raised about their clinical care. Among GAO’s findings:⁵⁴⁴

- “[R]eviews were not always documented or conducted in a timely manner.” More specifically, the VAMCs studied “were unable to provide documentation of these reviews for almost half of the 148 providers” and “did not start the reviews of 16 providers for 3 months to multiple years after the concerns were identified.”
- From October 2013 through March 2017, the VAMCs studied “did not report most of the providers who should have been reported to the National Practitioner Data Bank (NPDB) or state licensing boards (SLB) in accordance with VHA policy.”

“VA knowingly hires doctors with past malpractice claims, discipline for poor care,” USA TODAY, December 3, 2017.

A *USA TODAY* investigation revealed that “the Department of Veterans Affairs has repeatedly hired healthcare workers with problem pasts,”⁵⁴⁵ endangering the lives of our nation’s veterans. Among the examples uncovered:

- The VA knowingly hired a neurosurgeon who had “racked up more than a dozen malpractice claims and settlements in two states, including cases alleging he made surgical mistakes that left patients maimed, paralyzed or dead. He was accused of costing one patient bladder and bowel control after placing spinal screws incorrectly, he allegedly left another paralyzed from the waist down after placing a device improperly in his spinal canal. The state of Wyoming revoked his medical license after another surgical patient died.”
- “A VA hospital in Oklahoma knowingly hired a psychiatrist previously sanctioned for sexual misconduct who went on to sleep with a VA patient, according to internal documents.”
- “A Louisiana VA clinic hired a psychologist with felony convictions. The VA ended up firing him after they determined he was a ‘direct threat to others’ and the VA’s mission.”

“VA conceals shoddy care and health workers’ mistakes,” USA TODAY, October 13, 2017.

- “A *USA TODAY* investigation found the VA – the nation’s largest employer of health care workers – has for years concealed mistakes and misdeeds by staff members entrusted with the care of veterans.”⁵⁴⁶

- “In some cases, agency managers do not report troubled practitioners to the National Practitioner Data Bank, making it easier for them to keep working with patients elsewhere. The agency also failed to ensure VA hospitals reported disciplined providers to state licensing boards.”
- “In other cases, veterans’ hospitals signed secret settlement deals with dozens of doctors, nurses and health care workers that included promises to conceal serious mistakes – from inappropriate relationships and breakdowns in supervision to dangerous medical errors – even after forcing them out of the VA....”
- “Some employees who received the settlements were whistle-blowers or appear to have been wronged by the agency. In other cases, it’s clear the employees were the problem. In at least 126 cases, the VA initially found the workers’ mistakes or misdeeds were so serious that they should be fired. In nearly three-quarters of those settlements, the VA agreed to purge negative records from personnel files or give neutral or positive references to prospective employers.”
- “In 70 of the settlements, the VA banned employees from working in its hospitals for years – or life – even as the agency promised in most cases to conceal the specific reasons why.”

Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC, U.S. Department of Veterans Affairs, Office of Inspector General, 2017.

- The U.S. Department of Veterans Affairs’ Office of Inspector General (VA OIG) identified 194 instances during the past three years where hospital practices compromised patient safety.⁵⁴⁷
- The VA OIG also found that the following hazardous situations occurred in March and April 2017 – the “operating room at the hospital ran out of vascular patches to seal blood vessels and ultrasound probes used to map blood flow. The facility had to borrow bone material for knee replacement surgeries. And at one point, the hospital ran out of tubes needed for kidney dialysis, so staff had to go to a private-sector hospital and ask for some.”⁵⁴⁸ Two weeks later, “the dialysis unit ran out of dialyzer bloodlines and 15 gauge fistula needles, both of which are essential for dialysis treatments.”⁵⁴⁹

NOTES

¹ Twenty-two states plus the District of Columbia and Puerto Rico provided NCSC with state court caseload data related to medical malpractice cases as a percentage of total civil caseloads. National Center for State Courts, “2017 Civil Caseloads – Trial Courts: 2017 Statewide Medical Malpractice Caseloads and Rates,” http://popup.ncsc.org/CSP/CSP_Intro.aspx

² See National Center for State Courts, “2016 Civil Caseloads – Trial Courts: 2016 Statewide Medical Malpractice Caseloads and Rates” (0.17 percent), “2015 Civil Caseloads – Trial Courts: 2015 Statewide Medical Malpractice Caseloads and Rates” (0.16 percent), “2014 Civil Caseloads – Trial Courts: 2014 Statewide Medical Malpractice Caseloads and Rates” (0.14 percent), “2013 Civil Caseloads – Trial Courts: 2013 Statewide Medical Malpractice Caseloads and Rates” (0.14 percent) and “2012 Civil Caseloads – Trial Courts: 2012 Statewide Medical Malpractice Caseloads and Rates” (0.13 percent), http://popup.ncsc.org/CSP/CSP_Intro.aspx

³ Twenty-two states plus the District of Columbia and Puerto Rico provided NCSC with state court caseload data related to medical malpractice cases as a percentage of total tort caseloads. National Center for State Courts, “2017 Civil Caseloads – Trial Courts: 2017 Statewide Medical Malpractice Caseloads and Rates,” http://popup.ncsc.org/CSP/CSP_Intro.aspx

⁴ See National Center for State Courts, “Composition of Tort Caseloads in 20 States, 2016,” <http://www.courtstatistics.org/~media/Microsites/Files/CSP/Civil/PDFs/EWSC-2016-CIVIL-Page-6-Tort-Pie.ashx> (4 percent); National Center for State Courts, “2016 Civil Caseloads – Trial Courts: 2016 Statewide Medical Malpractice Caseloads and Rates” (4.15 percent), “2015 Civil Caseloads – Trial Courts: 2015 Statewide Medical Malpractice Caseloads and Rates” (4.6 percent), “2014 Civil Caseloads – Trial Courts: 2014 Statewide Medical Malpractice Caseloads and Rates” (3.9 percent), “2013 Civil Caseloads – Trial Courts: 2013 Statewide Medical Malpractice Caseloads and Rates” (4 percent) and “2012 Civil Caseloads – Trial Courts: 2012 Statewide Medical Malpractice Caseloads and Rates” (3.4 percent), http://popup.ncsc.org/CSP/CSP_Intro.aspx

⁵ Tom Baker and Charles Silver, “How Liability Insurers Protect Patients and Improve Safety,” *DePaul Law Rev.* (forthcoming), August 1, 2018, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3220642

⁶ *Ibid.*

⁷ This percentage comes from NCSC’s examination of tort caseload composition in 20 states. National Center for State Courts, “Composition of Tort Caseloads in 20 States, 2016” (2018) <http://www.courtstatistics.org/~media/Microsites/Files/CSP/Civil/PDFs/EWSC-2016-CIVIL-Page-6-Tort-Pie.ashx>. This percentage is also consistent with 2016 data provided to NCSC by 20 states plus the District of Columbia and Puerto Rico and released in November 2017, which showed that medical malpractice cases represent 4.15 percent of total state court tort caseloads. National Center for State Courts, “2016 Civil Caseloads – Trial Courts: 2016 Statewide Medical Malpractice Caseloads and Rates,” http://www.ncsc.org/Sitecore/Content/Microsites/PopUp/Home/CSP/CSP_Civil

⁸ See National Center for State Courts, “2015 Civil Caseloads – Trial Courts: 2015 Statewide Medical Malpractice Caseloads and Rates” (4.6 percent), “2014 Civil Caseloads – Trial Courts: 2014 Statewide Medical Malpractice Caseloads and Rates” (3.9 percent), “2013 Civil Caseloads – Trial Courts: 2013 Statewide Medical Malpractice Caseloads and Rates” (4 percent) and “2012 Civil Caseloads – Trial Courts: 2012 Statewide Medical Malpractice Caseloads and Rates” (3.4 percent), http://www.ncsc.org/Sitecore/Content/Microsites/PopUp/Home/CSP/CSP_Civil

⁹ Twenty states plus the District of Columbia and Puerto Rico provided NCSC with state court caseload data related to medical malpractice cases as a percentage of total civil caseloads. National Center for State Courts, “2016 Civil Caseloads – Trial Courts: 2016 Statewide Medical Malpractice Caseloads and Rates,” http://www.ncsc.org/Sitecore/Content/Microsites/PopUp/Home/CSP/CSP_Civil

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¹² Martin Makary and David E. Newman-Toker, “Measuring Diagnostic Errors in Primary Care,” *JAMA Internal Medicine*, March 25, 2013, <http://archinte.jamanetwork.com/article.aspx?articleid=1656536>

¹³ Public Citizen, *Medical Malpractice Payments Remained at Historic Low in 2013 Despite Slight Uptick* (October 2014), <http://www.citizen.org/documents/Medical-malpractice-2013.pdf>

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¹⁸ Mark A. Hofmann, “White House open to medical liability changes,” *Business Insurance*, January 30, 2011, <http://www.businessinsurance.com/article/20110130/ISSUE01/301309974>

¹⁹ David M. Studdert et al., “Claims, Errors, and Compensation Payments in Medical Malpractice Litigation,” 354 *N Engl J Med* 2024 (2006), <http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf>

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